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## INTRODUCTION

The Illinois Register is the official state document for publishing public notice of rulemaking activity initiated by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category.

Rulemaking activity consists of proposed or adopted new rules; amendments to or repealers of existing rules; and rules promulgated by emergency or peremptory action. Executive Orders and Proclamations issued by the Governor; notices of public information required by State Statute; and activities (meeting agendas; Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State Agencies; is also published in the Register.

The Register is a weekly update of the Illinois Administrative Code (a compilation of the rules adopted by State agencies). The most recent edition of the Code, along with the Register, comprise the most current accounting of State agencies' rulemakings.

The Illinois Register is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act [5 ILCS 100/1-1, et seq.].

### ILLINOIS REGISTER PUBLICATION SCHEDULE FOR 2013

<b>Issue#</b>	<b>Rules Due Date</b>	<b>Date of Issue</b>
1	December 26, 2012	January 4, 2013
2	December 31, 2012	January 11, 2013
3	January 7, 2013	January 18, 2013
4	January 14, 2013	January 25, 2013
5	January 22, 2013	February 1, 2013
6	January 28, 2013	February 8, 2013
7	February 4, 2013	February 15, 2013
8	February 11, 2013	February 22, 2013
9	February 19, 2013	March 1, 2013
10	February 25, 2013	March 8, 2013
11	March 4, 2013	March 15, 2013
12	March 11, 2013	March 22, 2013
13	March 18, 2013	March 29, 2013
14	March 25, 2013	April 5, 2013
15	April 1, 2013	April 12, 2013
16	April 8, 2013	April 19, 2013
17	April 15, 2013	April 26, 2013
18	April 22, 2013	May 3, 2013
19	April 29, 2013	May 10, 2013
20	May 6, 2013	May 17, 2013

21	May 13, 2013	May 24, 2013
22	May 20, 2013	May 31, 2013
23	May 28, 2013	June 7, 2013
24	June 3, 2013	June 14, 2013
25	June 10, 2013	June 21, 2013
26	June 17, 2013	June 28, 2013
27	June 24, 2013	July 5, 2013
28	July 1, 2013	July 12, 2013
29	July 8, 2013	July 19, 2013
30	July 15, 2013	July 26, 2013
31	July 22, 2013	August 2, 2013
32	July 29, 2013	August 9, 2013
33	August 5, 2013	August 16, 2013
34	August 12, 2013	August 23, 2013
35	August 19, 2013	August 30, 2013
36	August 26, 2013	September 6, 2013
37	September 3, 2013	September 13, 2013
38	September 9, 2013	September 20, 2013
39	September 16, 2013	September 27, 2013
40	September 23, 2013	October 4, 2013
41	September 30, 2013	October 11, 2013
42	October 7, 2013	October 18, 2013
43	October 15, 2013	October 25, 2013
44	October 21, 2013	November 1, 2013
45	October 28, 2013	November 8, 2013
46	November 4, 2013	November 15, 2013
47	November 12, 2013	November 22, 2013
48	November 18, 2013	December 2, 2013
49	November 25, 2013	December 6, 2013
50	December 2, 2013	December 13, 2013
51	December 9, 2013	December 20, 2013
52	December 16, 2013	December 27, 2013

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Testing Fees for Analytical Services
- 2) Code Citation: 35 Ill. Adm. Code 691
- 3) 

<u>Section Numbers</u> :	<u>Proposed Action</u> :
691.101	Amendment
691.102	Amendment
691.104	Amendment
691.105	Amendment
691.200	Amendment
691.201	Amendment
691.203	Repeal
691.301	Amendment
691.302	Amendment
691.303	Amendment
691.306	Repeal
691.401	Repeal
691.403	Repeal
- 4) Statutory Authority: Implementing and authorized by Section 17.7 of the Environmental Protection Act (415 ILCS 5/17.7)
- 5) A Complete Description of the Subjects and Issues Involved: This rulemaking will update the Illinois Environmental Protection Agency's (Illinois EPA) drinking water analysis program (Program) at 35 Ill. Adm. Code 691 in response to changes made to Section 17.7 of the Illinois Environmental Protection Act (415 ILCS 5/17.7) by P.A. 097-0220. Pursuant to Section 17.7, the Agency shall base its annual fee determination on actual and anticipated costs for testing. In addition, 35 Ill. Adm. Code 691 also establishes Program participation and non-participation procedures. At present, 35 Ill. Adm. Code 691 provides for a 3-year participation period in the Program. This rulemaking reduces the 3-year period to a 1-year participation period to correspond with the State's fiscal year. While community water supplies (CWS) are still provided the option to not participate in the Program, this rulemaking clarifies each CWS must notify the Agency of its intent to participate or not participate in the Program. Finally, this rulemaking reinforces if a CWS does not participate in the Program or does not pay the required fees, the Agency, as provided by statute, does not have the duty to analyze any drinking water samples.

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PROPOSED AMENDMENTS

- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? Yes

<u>Sections:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
691.101	Amendment	36 Ill. Reg. 10565; July 20, 2012
691.102	Amendment	36 Ill. Reg. 10565; July 20, 2012
691.104	Amendment	36 Ill. Reg. 10565; July 20, 2012
691.105	Amendment	36 Ill. Reg. 10565; July 20, 2012
691.200	Amendment	36 Ill. Reg. 10565; July 20, 2012
691.201	Amendment	36 Ill. Reg. 10565; July 20, 2012
691.203	Repeal	36 Ill. Reg. 10565; July 20, 2012
691.301	Amendment	36 Ill. Reg. 10565; July 20, 2012
691.302	Amendment	36 Ill. Reg. 10565; July 20, 2012
691.303	Amendment	36 Ill. Reg. 10565; July 20, 2012
691.306	Repeal	36 Ill. Reg. 10565; July 20, 2012
691.401	Repeal	36 Ill. Reg. 10565; July 20, 2012
691.403	Repeal	36 Ill. Reg. 10565; July 20, 2012

- 11) Statement of Statewide Policy Objectives: This rulemaking will amend 35 Ill. Adm. Code 691 to make it consistent with the statutory changes in Public Act 97-220, will update the language regarding the Program's notification and participation process, and reinforces duties to analyze drinking water samples as required by State and federal regulations. It does not create or expand a State mandate under the State Mandates Act [30 ILCS 805].
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on the proposed rules may submit them in writing by no later than 45 days after publication of this Notice to:

Sara G. Terranova  
Assistant Counsel

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PROPOSED AMENDMENTS

Illinois Environmental Protection Agency  
Division of Legal Counsel  
1021 North Grand Avenue East  
P.O. Box 19276  
Springfield, Illinois 62794-9276

217/782-5544  
sara.terranova@illinois.gov

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: Small businesses affected are those operating community water supplies that participate in the Illinois EPA's drinking water analysis program.
  - B) Reporting, bookkeeping or other procedures required for compliance: The amendments reflect a statutory change in Illinois EPA testing fees. They do not require the preparation of a report or record, and do not require any new reporting, recordkeeping or other administrative costs for compliance.
  - C) Types of Professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: January 2013

The full text of the Proposed Amendments begins on the next page:

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENTS

TITLE 35: ENVIRONMENTAL PROTECTION  
SUBTITLE F: PUBLIC WATER SUPPLIES  
CHAPTER II: ENVIRONMENTAL PROTECTION AGENCY

PART 691  
TESTING FEES FOR ANALYTICAL SERVICES

SUBPART A: GENERAL

- Section
- 691.101 Purpose and Applicability
- 691.102 Definitions
- 691.103 Payment of Annual Testing Fee Required Prior to Laboratory Testing by the Agency (Repealed)
- 691.104 Period of Program Participation
- | 691.105 ~~Participation~~Nonparticipation in the Program
- 691.106 Relation to Other Fee Systems (Repealed)
- 691.107 Severability

SUBPART B: PROGRAM PARTICIPATION FEES

- Section
- 691.200 Fee Payment
- 691.201 Calculation of Fee
- 691.202 Annual Testing Fee After Calendar Year 1990 (Repealed)
- | 691.203 Determining the Number of Service Connections (~~Repealed~~)

SUBPART C: PROCEDURES FOR BILLING AND COLLECTING PROGRAM PARTICIPATION FEES

- Section
- | 691.301 ~~Fee~~Billing Statements
- | 691.302 ~~Due Date of~~ Payment
- 691.303 Form of Payment
- 691.304 Prohibition Against Refund (Repealed)
- 691.305 Overpayment or Underpayment of Program Participation Fee
- | 691.306 Audit and Access to Records (~~Repealed~~)

SUBPART D: DISPUTE RESOLUTION PROCEDURES

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

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## Section

- 691.401 Council's Non-Concurrence With the Agency Fee Determination ~~(Repealed)~~  
 691.403 Dispute Resolution ~~(Repealed)~~

691.APPENDIX A Agreement for Reduced Participation in Sample Analysis  
 (Repealed)

AUTHORITY: Implementing and authorized by Section 17.7 of the Environmental Protection Act [415 ILCS 5/17.7].

SOURCE: Adopted at 14 Ill. Reg. 2045, effective January 18, 1990; amended at 19 Ill. Reg. 12648, effective August 24, 1995; amended at 33 Ill. Reg. 7072, effective May 13, 2009; amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

## SUBPART A: GENERAL

**Section 691.101 Purpose and Applicability**

- a) The purpose of this Part is to establish procedures for participation by community water supplies in the Agency's drinking water analysis program and for the determination and collection of fees for participation in the ~~Program~~program.
- b) This Part applies to community water supplies. Each community water supply in the State ~~must declare its intention to participate or not participate~~is a participant in the Agency's drinking water analysis program ~~unless it declares its intent to not participate~~, as authorized by Section 691.105(a)(2) and (b)(1)(e) of this Part.

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 691.102 Definitions**

- a) Unless specified otherwise, all terms shall have the meaning set forth in the Act.
- b) For purposes of this Part, the following definitions apply:
- "Act" means the Environmental Protection Act [415 ILCS 5].
- "Agency" means the Illinois Environmental Protection Agency.

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

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"Board" means the Illinois Pollution Control Board.

"Certified laboratory" means any laboratory approved by the Agency pursuant to 35 Ill. Adm. Code 183, or other department or agency of State government if such authority is delegated for the specific parameters to be examined, pursuant to Section 4(n) or (o) of the Act.

"Community water supply" or "supply" means a public water supply which serves or is intended to serve at least 15 service connections used by residents or regularly serves at least 25 residents. (Section 3.145 of the Act)

"Council" means the Community Water Supply Testing Council established by Section 17.7(f) of the Act.

"Drinking water analysis program" or "Program" means the laboratory analysis of community water supplies by the Agency for any community water supply that ~~declares its intention to participate or not participatedoes not declare its intent to not participate, as authorized by in accordance with~~ Section 691.105(a)(2) and (b)(1)(e); and pays the fees established pursuant to Subpart B of this Part.

"Laboratory testing" means the analysis of drinking water by the Agency required under 35 Ill. Adm. Code Subtitle F and federal regulations established under the Safe Drinking Water Act (42 USC 300f).

~~"Parent community water supply" or "Parent supply" is a community water supply that uses or sells potable water derived from its own sources or receives only a portion of its potable water from other potable water sources.~~

"Program participation fee" or "fee" means the amount due from the community water supply for analytical services under the Program.

"Public water supply" or "PWS" means all mains, pipes and structures through which water is obtained and distributed to the public, including wells and well structures, intakes and cribs, pumping stations, treatment plants, reservoirs, storage tanks and appurtenances, collectively or severally, actually used or intended for use for the purpose of furnishing water for drinking or general domestic use and which serve at least 15 service connections or which regularly serve at least 25 persons at least 60 days per year. A public water supply is either

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

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a "community water supply" or a "non-community water supply". (Section 3.365 of the Act)

~~"Purchasing community water supply" or "Purchasing supply" is a community water supply that purchases or receives its potable water entirely from another potable water source.~~

~~"Service connection" means the opening, including all fittings and appurtenances at the water main through which water is supplied to the user.~~

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 691.104 Period of Program Participation**

Except as provided by Section 691.105(b), each community water supply shall participate in the ~~Program annually during each State fiscal year program for a 3-year period commencing July 1, 1995, and for additional 3-year periods thereafter. Any community water supply entering the program after the commencement of a 3-year period will be assigned a period of participation designed to expire at the end of the current 3-year cycle.~~

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 691.105 Participation ~~Nonparticipation~~ in the Program**a) Notification and Participation

1) ~~Prior to May 31 of each year, In January of the year in which the 3-year program period commences,~~ the Agency will notify each community water supply of the supply's options for participation in the Program during the State's next fiscal year. ~~option to not participate in the Program and to have its drinking water analyses performed by a certified laboratory operated by an entity other than the Agency. This notification~~ Each year, ~~the Agency~~ will inform the community water supply of the fee for Program ~~program~~ participation that has been determined ~~for that community water supply~~ as provided in Subpart B of this Part.

2) Within 45 days after issuance of notice under subsection (a)(1), each community water supply must indicate its intention to participate in the

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

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Program during the State's next fiscal year by notifying the Agency, using the election form provided by the Agency.

3) Community water supplies that do not submit an election form under subsection (a)(2) or (b)(1) must have their drinking water analyses performed by a certified laboratory operated by an entity other than the Agency.

b) Notification and Nonparticipation

1) Any community water supply ~~electing may indicate its intention~~ to not participate in the Program during the State's next fiscal year must notify ~~notifying~~ the Agency, using the election form provided by the Agency, within 45 days after issuance of the notice under subsection (a)(1).

2) Community water supplies that do not submit an election form under subsection (a)(2) or (b)(1) must have their drinking water analyses performed by a certified laboratory operated by an entity other than the Agency.

c) No ~~Program~~ ~~program~~ participation fee shall be due from any community water supply that duly notifies the Agency of its nonparticipation as required by subsection (b)(1).

d) If the community water supply declares its nonparticipation in the ~~Program~~ ~~program~~ or fails to pay the required fees, or does not submit an election form under subsection (a)(2) or (b)(1), the Agency shall not perform any laboratory testing for the supply during the ~~Program~~ ~~program~~ participation period unless the services are otherwise paid for, ~~except that the Agency has the duty under Section 4(p) of the Act to analyze samples from such community water supplies only for:~~

1) ~~Up to six total coliform samples per sampling period as required under Section 4(p) of the Act; and~~

2) ~~Contaminants for which a maximum allowable concentration in finished drinking water has been established by Board regulation in 35 Ill. Adm. Code, Subtitle F prior to January 1, 1988.~~

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

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- e) *Community water supplies that choose not to participate in the laboratory fee program, ~~or do not pay the fees, or do not return the election form~~, shall have the duty to analyze all drinking water samples as required by State or federal safe drinking water regulations established after enactment of the federal Safe Drinking Water Act Amendments of 1986. (Section 17.7 of the Act).*

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## SUBPART B: PROGRAM PARTICIPATION FEES

**Section 691.200 Fee Payment**

- a) Community water supplies must pay all annual ~~testing~~ fees due under this Part prior to the initiation of any laboratory testing by the Agency.
- b) Payment of fees under this Part does not entitle a community water supply to any analytical services other than those provided by the Program.

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 691.201 Calculation of Fee**

~~a) The Agency, with the concurrence of the Council, shall determine the fee for participating in the laboratory fee program for analytical services Program pursuant to Section 17.7 of the Act. The Agency shall base its annual fee determination shall be based upon the actual and anticipated costs for testing under State and federal drinking water regulations and the associated administrative costs of the Agency and the Council. [\(Section 17.7\(b\) of the Act\)](#)~~

- ~~b) *By October 1 of each year, the Agency shall submit its fee determination and supporting documentation for the forthcoming calendar year to the Council. Before the following January 1, the Council shall hold at least one regular meeting to consider the Agency's determination. If the Council concurs with the Agency's determination, it shall take effect.* (Section 17.7 of the Act)~~

- ~~e) *In determining the fees, the Agency and the Council shall consider, but are not limited to, the following criteria:*~~

- ~~1) *number of service connections of the community water supply (see Section 691.203);*~~

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- 2) ~~maximum and minimum testing fees for all community water supplies;~~
- 3) ~~single or multiple payment plans for annual or multi-year fees; and~~
- 4) ~~testing requirement differences among community water supplies based on considerations including but not limited to the following:~~
  - A) ~~the potable water is derived from a groundwater or surface water source;~~
  - B) ~~the community water supply is a parent or purchasing supply; or~~
  - C) ~~the differences in required analytical services.~~

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 691.203 Determining the Number of Service Connections (Repealed)**

- a) ~~For purposes of determining the testing fee under Sections 691.201, the community water supply shall include only those service connections for which the community water supply is:~~
  - 1) ~~Directly metering or collecting revenue; or~~
  - 2) ~~Otherwise providing delivery of potable water.~~
- b) ~~When finished water is sold to another community water supply, the selling community water supply shall not include the service connections of the purchasing community water supply for purposes of calculating the testing fee under Sections 691.201. The purchasing community water supply shall include its service connections for purposes of calculating the testing fee under Sections 691.201.~~

(Source: Repealed at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

SUBPART C: PROCEDURES FOR BILLING AND  
COLLECTING PROGRAM PARTICIPATION FEES

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

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**Section 691.301 ~~Fee Billing~~ Statements**

The Agency shall send a ~~fee billing~~ statement ~~for the testing fee~~ to each community water supply ~~with the notice for Program participation provided pursuant to Section 691.105(a)(1) in January of each calendar year.~~

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 691.302 ~~Due Date of Payment~~**

~~Program participation fees~~ ~~The due date of payment~~ shall be paid within 45 days after issuance of the ~~fee billing~~ statement to the community water supply. Fee payments must accompany the election form submitted pursuant to Section 691.105(a)(2).

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 691.303 Form of Payment**

- a) Payment of Program participation fees must be by check or money order payable to "Illinois EPA" "Treasurer, State of Illinois" and shall be accompanied by the name of the community water supply and the facility identification number assigned by the Agency's Division of Public Water Supplies.
- b) Payment and all supporting documentation must be mailed together in a single package to:

Illinois Environmental Protection Agency  
Fiscal #2  
Attn: Fee Coordinator  
1021 North Grand Avenue East  
Data Entry and Cash Receipts Unit  
Fiscal Services Section  
P.O. Box 19276  
Springfield, Illinois 62794-9276

- c) Payment shall not include any fees due to the Agency for any purpose other than participation in the Program.
- d) Any ~~testing~~-fee remitted to the Agency shall not be refunded at any time or for

## ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

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any reason, either in whole or in part.

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 691.306 Audit and Access to Records (Repealed)**

- a) ~~Each community water supply participating in the Program shall preserve and maintain all records relating to the number of service connections used in calculating the fee for at least 5 years after the close of the participation.~~
- b) ~~The records described in subsection (a) shall be available to the Agency or its authorized representative for examination during normal business hours.~~

(Source: Repealed at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## SUBPART D: DISPUTE RESOLUTION PROCEDURES

**Section 691.401 Council's Non-Concurrence With the Agency Fee Determination (Repealed)**

~~If the Council does not concur with the Agency fee determination by January 1 of the calendar year in which the testing fee was intended to be effective or if the Agency and the Council do not agree on any other issue related to the testing fee program by January 1 of the same calendar year, the Agency and the Council shall make every effort to resolve the dispute in question within the time frame established in Section 691.403 below.~~

(Source: Repealed at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 691.403 Dispute Resolution (Repealed)**

- a) ~~If the Agency and the Council cannot agree on issues related to the program, the Council shall initiate procedures for an external audit of the program.~~
- b) ~~The results of the external audit, including the recommendation, shall serve as the basis for Agency and Council deliberations regarding the issue in dispute.~~
- c) ~~If the conclusions of the external audit will not be completed by January 1 of the calendar year in which the testing fee was intended to take effect, the Agency shall issue billing statements to community water supplies in amounts that are~~

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENTS

~~derived from the Agency fee determination.~~

- d) ~~If the Agency and the Council deliberations conclude that, based upon the external audit, the fee should be different from the Agency fee determination amount, the Agency shall make the necessary adjustments in the subsequent fiscal year's Agency fee determination amount.~~

(Source: Repealed at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## ILLINOIS GAMING BOARD

## NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Video Gaming (General)
- 2) Code Citation: 11 Ill. Adm. Code 1800
- 3) 

<u>Section Numbers</u> :	<u>Proposed Action</u> :
1800.110	Amendment
1800.810	Amendment
1800.1010	Amendment
1800.1410	Amendment
1800.1420	New
- 4) Statutory Authority: Authorized by Section 78 (a) (3) and (b) of the Video Gaming Act [230 ILCS 40]
- 5) A Complete Description of the Subjects and Issues Involved: The rulemaking makes the following changes to the Part:

Inclusion of unredeemed vouchers as part of adjusted gross receipts. The proposed rulemaking adds a definition of "adjusted gross receipts" to Section 110 (Definitions). Under the new definition, "adjusted gross receipts" are defined as gross receipts less winnings paid to wagerers. The definition further provides that the value of expired vouchers shall be included in computing adjusted gross receipts. Including the value of expired vouchers as part of adjusted gross receipts conforms with standard accounting practice in the gaming industry.

Restricted areas for video gaming. A new paragraph added to Section 810 (Location and Placement of Video Gaming Terminals) establishing the following requirements relating to restricted areas for video gaming:

- For those locations that restrict admittance to patrons 21 years of age or older, a separate restricted area is not required.
- For those locations where separation from minors under 21 is required, a physical barrier to the gaming area, which may be a short partition, gate, rope or other barrier, is required. No barrier shall visually obscure the entrance to the gaming area from an employee of the location who is over the age of 21.

The above requirements are already set forth in the answer to Frequently Asked Question #13 for video gaming on the Illinois Gaming Board website. Thus, this rule change represents a codification of existing board policy.

## ILLINOIS GAMING BOARD

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Transfers of video gaming terminals (VGTs) between terminal operators. Currently, the Video Gaming Act and rules do not specify whether a licensed terminal operator may sell or otherwise transfer a video gaming terminal to another licensed terminal operator. The proposed rule change brings clarity to this issue. It amends Section 1010 (Restriction on Sale, Distribution, Transfer, Supply, and Operation of Video Gaming Terminals) to authorize such a sale or transfer only with the prior written approval of the Administrator.

Additional record-keeping requirements for facility payments. A "facility payment" is defined in the video gaming rules as a manual payment of currency by an authorized employee of a licensed video gaming location or terminal operator for amounts owed to a patron by a video gaming terminal when a video gaming terminal or ticket payout device has malfunctioned and is unable to produce or redeem a ticket. Section 1410(e) (Ticket Payout Devices) currently requires all facility payments to be accounted for by the licensed terminal operator and licensed video gaming location using Generally Accepted Accounting Principles (GAAP). As an additional check on accuracy and honesty, the proposed rule amends Section 1410 e) to require the recording of the following information for each facility payment:

- Date and time of the payment event;
- Amount paid;
- Video gaming terminal license number, payout device number, or video gaming ticket number for which payment is made; and
- Name of the individual processing the facility payment.

Redemption of tickets following removal or unavailability of a ticket payout device. This proposed change adds a new Section 1420 (Redemption of Tickets Following Removal or Unavailability of Ticket Payout Devices) addressing ticket redemption procedures in the following two situations:

- A video gaming location changes both terminal providers and ticket payout systems, thereby rendering tickets unredeemable by the new ticket payout device at the location; or

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- A location either ceases video gaming operations or suspends them for more than 10 days because of closure, change of location, revocation or suspension of liquor or video gaming license, or other cause.

In instances when a location changes terminal providers and ticket payout systems, the rulemaking requires the location to provide facility payments to the patrons for tickets issued under the previous terminal operator.

In instances when a location ceases video gaming operations or suspends them for more than 10 days, the rulemaking requires the location to inform patrons of the name and phone number of the terminal operator from which patrons can seek payment for unredeemed tickets, using both of the following informational methods:

- Placing a prominent sign at the location (the dimensions of which are specified in the rulemaking); and
- Placing a prominent notice on any internet site or social media outlet under the location's operation or control.

For all situations covered by this rulemaking, the terminal operator must maintain or secure a list or database of all issued and unredeemed tickets from the affected location. This list or database must be maintained for not less than one year.

- 6) Published studies and reports, and underlying sources of data, used to compose this rulemaking: None
- 7) Will this proposed rulemaking replace any emergency rulemaking currently in effect?  
No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this proposed rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate under 30 ILCS 805.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Any interested person may submit comments in writing concerning this

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proposed rulemaking not later than 45 days after publication of this notice in the *Illinois Register* to:

Emily Mattison  
General Counsel  
Illinois Gaming Board  
160 North LaSalle Street  
Chicago, Illinois 60601

Phone: 312/814-7253  
Fax: 312/814-7253  
e-mail: emily.mattison@igb.illinois.gov

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: The proposed rulemaking will impose no additional requirements.
  - C) Types of Professional skills necessary for compliance: The proposed rulemaking will impose no additional requirements.
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not summarized in a regulatory agenda because the Board did not anticipate the need for rulemaking at the time the previous two agendas were published.

The full text of the Proposed Amendments begins on the next page.

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TITLE 11: ALCOHOL, HORSE RACING, LOTTERY, AND VIDEO GAMING  
SUBTITLE D: VIDEO GAMING  
CHAPTER I: ILLINOIS GAMING BOARD

PART 1800  
VIDEO GAMING (GENERAL)

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## Section

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1800.630	Discovery
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1800.710	Coverage of Subpart
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1800.735	Discovery
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SUBPART H: LOCATION OF VIDEO GAMING TERMINALS IN  
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SUBPART J: TRANSPORTATION, REGISTRATION,  
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## SUBPART L: FINGERPRINTING OF APPLICANTS

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1800.1310 Public Requests for Information

## SUBPART N: PAYOUT DEVICES AND REQUIREMENTS

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## SUBPART O: NON-PAYMENT OF TAXES

Section  
1800.1510 Non-Payment of Taxes

AUTHORITY: Implementing and authorized by the Video Gaming Act [230 ILCS 40].

SOURCE: Adopted by emergency rulemaking at 33 Ill. Reg. 14793, effective October 19, 2009, for a maximum of 150 days; adopted at 34 Ill. Reg. 2893, effective February 22, 2010; emergency amendment at 34 Ill. Reg. 8589, effective June 15, 2010, for a maximum of 150 days; emergency expired November 11, 2010; amended at 35 Ill. Reg. 1369, effective January 5, 2011; emergency amendment at 35 Ill. Reg. 13949, effective July 29, 2011, for a maximum of 150 days; emergency expired December 25, 2011; amended at 36 Ill. Reg. 840, effective January 6,

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2012; amended by emergency rulemaking at 36 Ill. Reg. 4150, effective February 29, 2012, for a maximum of 150 days; amended at 36 Ill. Reg. 5455, effective March 21, 2012; amended at 36 Ill. Reg. 10029, effective June 28, 2012; emergency amendment at 36 Ill. Reg. 11492, effective July 6, 2012, for a maximum of 150 days; emergency expired December 2, 2012; emergency amendment at 36 Ill. Reg. 12895, effective July 24, 2012, for a maximum of 150 days; amended at 36 Ill. Reg. 13178, effective July 30, 2012; amended at 36 Ill. Reg. 15112, effective October 1, 2012; amended at 36 Ill. Reg. 17033, effective November 21, 2012; amended at 36 Ill. Reg. 18550, effective December 14, 2012; amended at 37 Ill. Reg. 810, effective January 11, 2013; amended at 37 Ill. Reg. 4892, effective April 1, 2013; amended at 37 Ill. Reg. 7750, effective May 23, 2013; amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

## SUBPART A: GENERAL PROVISIONS

**Section 1800.110 Definitions**

For purposes of this Part the following terms shall have the following meanings:

"Act": The Video Gaming Act [230 ILCS 40].

"Adjusted gross receipts" means the gross receipts less winnings paid to wagerers. The value of expired vouchers shall be included in computing adjusted gross receipts.

"Administrator": The chief executive officer responsible for day-to-day operations of the Illinois Gaming Board.

"Affiliate": An "affiliate of", or person "affiliated with", a specified person shall mean a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, such person.

"Affiliated entity": An "affiliated entity" of a person is any business entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, the person.

"Applicant": A person applying for any license under the Act.

"Application": All material submitted, including the instructions, definitions, forms and other documents issued by the Illinois Gaming Board, comprising the video gaming license application submitted to the Illinois Gaming Board.

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"Associated video gaming equipment": Ticket payout systems and validation procedures; wireless, promotional and bonusing systems; kiosks; gaming-related peripherals; hardware, software and systems; and other gaming devices and equipment for compliance with:

Illinois laws, regulations and requirements as codified or otherwise set forth; and

Board-approved video gaming industry standards.

"Attributed interest": A direct or indirect interest in an enterprise deemed to be held by an individual not through the individual's actual holdings but either through the holdings of the individual's relatives or through a third party or parties on behalf of the individual pursuant to a plan, arrangement, agreement or contract.

"Board": The Illinois Gaming Board.

"Business entity" or "Business": A partnership, incorporated or unincorporated association or group, firm, corporation, limited liability company, partnership for shares, trust, sole proprietorship or other business enterprise.

"Chi-square test": A statistical test used to determine if a relationship between variables exists by comparing expected and observed cell frequencies. Specifically, a chi-square test examines the observed frequencies in a category and compares them to what would be expected by chance or would be expected if there was no relationship between variables.

"Control": The possession, direct or indirect, of power to direct or cause the direction of the management and policies of an applicant or licensee through the ownership of voting securities, by contract or otherwise.

"Convenience store": A retail store that is open long hours and sells motor fuel and a limited selection of snacks and general goods.

"Credit": One, five, 10 or 25 cents.

"Distributor": An individual, partnership, corporation or limited liability company licensed under the Act to buy, sell, lease or distribute video gaming

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terminals or major components or parts of video gaming terminals to or from terminal operators.

"Enforce a security interest": To transfer possession of ownership or title pursuant to a security interest.

"EPROM": An acronym for Erasable, Programmable, Read Only Memory, which is a microprocessor component that stores memory and affects payout percentage and/or contains a random number generator that selects the outcome of a game on a video gaming terminal.

"Facility-pay" or "facility payment" means a manual payment of currency by an authorized employee of a licensed video gaming location or an authorized employee of a terminal operator for amounts owed to a patron by a video gaming terminal when a video gaming terminal or ticket payout device has malfunctioned and is unable to produce or redeem a ticket.

"Fraternal organization": An organization or institution organized and conducted on a not-for-profit basis with no personal profit inuring to anyone as a result of the operation and that is exempt from federal income taxation under section 501(c)(8) or (c)(10) of the Internal Revenue Code (26 USC 501(c)(8) or (c)(10)).

"Game": A gambling activity that is played for money, property or anything of value, including without limitation those played with cards, chips, tokens, vouchers, dice, implements, or electronic, electrical or mechanical devices or machines.

"Gaming": The dealing, operating, carrying on, conducting, maintaining or exposing for play of any game.

"Gaming operation": The conducting of gaming or the providing or servicing of gaming equipment.

"Gaming property collateral": Video gaming equipment subject to a security interest.

"Illinois resident":

With respect to an individual, an individual who is either:

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domiciled in Illinois or maintains a bona fide place of abode in Illinois; or

is required to file an Illinois tax return during the taxable year.

With respect to a corporation, any corporation organized under the laws of this State and any foreign corporation with a certificate of authority to transact business in Illinois. A foreign corporation not authorized to transact business in this State is a nonresident of this State.

With respect to a partnership, a partnership in which any partner is an Illinois resident, or where the partnership has an office and is doing business in Illinois.

With respect to an irrevocable trust, a trust where the grantor was an Illinois resident individual at the time the trust became irrevocable.

"Institutional investor":

A retirement fund administered by a public agency for the exclusive benefit of federal, state or local public employees;

An investment company registered under section 8 of the Investment Company Act of 1940 (15 USC 80a-8);

A collective investment trust organized by a bank under Part 9 of the Rules of the Comptroller of the Currency (12 CFR 9.18);

A closed end investment trust registered with the United States Securities and Exchange Commission;

A chartered or licensed life insurance company or property and casualty insurance company;

A federal or state bank;

An investment advisor registered under the Investment Advisors Act of 1940 (15 USC 80b-1 through 80b-21); or

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Such other person as the Illinois Gaming Board may determine for reasons consistent with the Act and this Part.

"License": Authorization granted by the Board permitting a licensee to engage in the defined activities of video gaming.

"Licensed establishment": Any retail establishment licensed under the Act where alcoholic liquor is drawn, poured, mixed, or otherwise served for consumption on the premises. Licensed establishment does not include a facility operated by an organization licensee, an intertrack wagering licensee, or an intertrack wagering location licensee licensed under the Illinois Horse Racing Act of 1975 [230 ILCS 5] or a riverboat licensed under the Riverboat Gambling Act [230 ILCS 10].

"Licensed fraternal establishment": The location licensed under the Act where a qualified fraternal organization that derives its charter from a national fraternal organization regularly meets.

"Licensed technician": An individual who is licensed under the Act to repair, service and maintain video gaming terminals.

"Licensed terminal handler": A person, including but not limited to an employee or independent contractor working for a manufacturer, distributor, supplier, technician or terminal operator, who is licensed under the Act to possess or control a video gaming terminal or to have access to the inner workings of a video gaming terminal. A licensed terminal handler does not include an individual, partnership, corporation or limited liability company defined as a manufacturer, distributor, supplier, technician or terminal operator under Section 5 of the Act.

"Licensed truck stop establishment": A facility licensed under the Act that is at least a 3-acre facility with a convenience store, that has separate diesel islands for fueling commercial motor vehicles, that sells at retail more than 10,000 gallons of diesel or biodiesel fuel per month, and that has parking spaces for commercial motor vehicles. "Commercial motor vehicles" has the same meaning as defined in Section 18b-101 of the Illinois Vehicle Code [625 ILCS 5/18b-101]. The 10,000 gallon requirement may be met by showing that estimated future sales or past sales average at least 10,000 gallons per month.

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"Licensed veterans establishment": The location licensed under the Act where a qualified veterans organization that derives its charter from a national veterans organization regularly meets.

"Licensed video gaming location": A licensed establishment, licensed fraternal establishment, licensed veterans establishment, or licensed truck stop establishment, all as defined in Section 5 of the Act and this Part.

"Liquor license": A license issued by a governmental body authorizing the holder to sell and offer for sale at retail alcoholic liquor for use or consumption.

"Major components or parts": Components or parts that comprise the inner workings and peripherals of a video gaming terminal, including but not limited to the device's hardware, software, human interface devices, interface ports, power supply, ticket payout system, bill validator, printer and any component that affects or could affect the result of a game played on the device.

"Manufacturer": An individual, partnership, corporation or limited liability company that is licensed under the Act and that manufactures or assembles video gaming terminals.

"Net terminal income": Money put into a video gaming terminal minus credits paid out to players.

"Nominee": Any individual or business entity that holds as owner of record the legal title to tangible or intangible personal or real property, including without limitation any stock, bond, debenture, note, investment contract or real estate on behalf of another individual or business entity, and as such is designated and authorized to act on his, her or its behalf with respect to the property.

"Ownership interest": Includes, but is not limited to, direct, indirect, beneficial or attributed interest, or holder of stock options, convertible debt, warrants or stock appreciation rights, or holder of any beneficial ownership or leasehold interest in a business entity.

"Payout device": A device, approved by the Board and provided by a supplier or distributor, that redeems for cash tickets dispensed by a video gaming terminal in exchange for credits accumulated on a video gaming terminal.

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"Person": Includes both individuals and business entities.

"Person with significant interest or control": Any of the following:

Each person in whose name the liquor license is maintained for each licensed video gaming location;

Each person who, in the opinion of the Administrator, has the ability to influence or control the activities of the applicant or licensee, or elect a majority of its board of directors, other than a bank or licensed lending institution that holds a mortgage or other lien, or any other source of funds, acquired in the ordinary course of business;

Persons having the power to exercise significant influence or control over decisions concerning any part of the applicant's or licensee's video gaming operation.

"Place of worship under the Religious Corporation Act": A structure belonging to, or operated by, a church, congregation or society formed for the purpose of religious worship and eligible for incorporation under the Religious Corporation Act [805 ILCS 110], provided that the structure is used primarily for purposes of religious worship and related activities.

"Redemption period": The one-year period, starting on the date of issuance, during which a ticket dispensed by a video gaming terminal may be redeemed for cash.

"Secured party": A person who is a lender, seller or other person who holds a valid security interest.

"Security": An ownership right or creditor relationship.

"Security agreement": An agreement that creates or provides a security interest, including but not limited to a use agreement.

"Security interest": An interest in property that secures the payment or performance of an obligation or judgment.

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"Sole proprietor": An individual who in his or her own name owns 100% of the assets and who is solely liable for the debts of a business.

"Substantial interest": With respect to a partnership, a corporation, an organization, an association, a business or a limited liability company means:

When, with respect to a sole proprietorship, an individual or his or her spouse owns, operates, manages, or conducts, directly or indirectly, the organization, association or business, or any part thereof; or

When, with respect to a partnership, the individual or his or her spouse shares in any of the profits, or potential profits, of the partnership activities; or

When, with respect to a corporation, an individual or his or her spouse is an officer or director or the individual or his or her spouse is a holder, directly or beneficially, of 5% or more of any class of stock of the corporation; or

When, with respect to a limited liability company, an individual or his or her spouse is a member, or the individual or his or her spouse is a holder, directly or beneficially, of 5% or more of the membership interest of the limited liability company; or

When, with respect to any other organization not covered in the preceding four paragraphs, an individual or his or her spouse is an officer or manages the business affairs, or the individual or his or her spouse is the owner of, or otherwise controls, 10% or more of the assets of the organization; or

When an individual or his or her spouse furnishes 5% or more of the capital, whether in cash, goods or services, for the operation of any business, association or organization during any calendar year.

For purposes of this definition, "individual" includes all individuals or their spouses whose combined interest would qualify as a substantial interest under this definition and whose activities with respect to an organization, association, or business are so closely aligned or coordinated as to constitute the activities of a single entity.

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"Supplier": An individual, partnership, corporation or limited liability company that is licensed under the Act to supply major components or parts to video gaming terminals to licensed terminal operators.

"Terminal operator": An individual, partnership, corporation or limited liability company that is licensed under the Act that owns, services, and maintains video gaming terminals for placement in licensed establishments, licensed truck stop establishments, licensed fraternal establishments or licensed veterans establishments.

"Use agreement": A contractual agreement between a licensed terminal operator and a licensed video gaming location establishing terms and conditions for placement and operation of video gaming terminals by the licensed terminal operator within the premises of the licensed video gaming location.

"Veterans organization": An organization or institution organized and conducted on a not-for-profit basis with no personal profit inuring to anyone as a result of the operation and that is exempt from federal income taxation under section 501(c)(19) of the Internal Revenue Code (26 USC 501(c)(19)).

"Video gaming equipment": Video gaming terminals, associated video gaming equipment and major components or parts.

"Video gaming operation": As the context requires, the conducting of video gaming and all related activities.

"Video gaming terminal": Any electronic video game machine that, upon insertion of cash, is available to play or simulate the play of a video game, including but not limited to video poker, line up and blackjack, as authorized by the Board utilizing a video display and microprocessors in which the player may receive free games or credits that can be redeemed for cash. The term does not include a machine that directly dispenses coins, cash, or tokens or is for amusement purposes only.

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

SUBPART H: LOCATION OF VIDEO GAMING TERMINALS IN  
LICENSED VIDEO GAMING LOCATIONS

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**Section 1800.810 Location and Placement of Video Gaming Terminals**

- a) All licensed video gaming locations and terminal operators shall be responsible for the proper placement, installation, maintenance and oversight of video gaming terminals within a licensed video gaming location as prescribed by the Act and this Part.
- b) All video gaming terminals must be located in an area restricted to persons over 21 years of age. For all licensed video gaming locations that restrict admittance to patrons 21 years of age or older, a separate restricted area is not required. Any licensed video gaming location that allows minors to enter where video gaming terminals are located shall separate any video gaming terminals from the area accessible by minors. In those licensed video gaming locations where separation from minors under 21 is required, a physical barrier to the gaming area is required, which may consist of a short partition, gate or rope or other means of separation. No barrier shall visually obscure the entrance to the gaming area from an employee of the licensed video gaming location who is over the age of 21.
- c) When two or more adjacent businesses appear to the Administrator to be a single business, or are operated by the same or commingled ownership, then the Administrator may limit those businesses to the maximum number of video gaming terminals. The maximum will be the number permitted under Illinois law for one business as the total number of video gaming terminals authorized for both or more such businesses, where the Administrator determines that the limitation would further the intent of the Act and the integrity of video gaming in the State of Illinois.
  - 1) In the event the Administrator decides that two or more adjacent businesses shall be a single business for purposes of determining the maximum number of video gaming terminals to which they are entitled, the Administrator shall provide the affected businesses with written notice of this decision in accordance with the notice requirements of Section 1800.615.
  - 2) An applicant that has been deemed to constitute a single business with one or more adjacent businesses for purposes of determining the maximum number of video gaming terminals to which it is entitled may submit a request for hearing to the Board. The hearing procedures shall be those set forth in Subpart F.

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- d) The owner, manager or employee of the licensed video gaming location who is over 21 years of age shall be present during all hours of operation, and the video gaming terminals or the entrance to the video gaming terminal area must be within the view of at least one owner, manager or employee.

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

SUBPART J: TRANSPORTATION AND DISTRIBUTION  
OF VIDEO GAMING TERMINALS**Section 1800.1010 Restriction on Sale, Distribution, Transfer, Supply, and Operation of Video Gaming Terminals**

- a) No licensee shall sell, distribute, transfer or supply a video gaming terminal to any person that could not lawfully own or operate the video gaming terminal.
- b) No terminal operator or licensed video gaming location shall operate a video gaming terminal without first obtaining a terminal operator's license or a license for a video gaming location, as applicable.
- c) A terminal operator may sell or otherwise transfer a video gaming terminal to another terminal operator only with prior written approval of the Administrator.

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## SUBPART N: PAYOUT DEVICES AND REQUIREMENTS

**Section 1800.1410 Ticket Payout Devices**

- a) Each licensed video gaming location at which video gaming terminals are available shall have a payout device as defined in Section 1800.110.
- b) In addition to the requirement set forth in this Section, each payout device shall conform to the redemption terminal interoperability requirements approved by the Administrator and to the video gaming payout device standards approved by the Administrator. A licensed video gaming location shall only use a payout device that has received prior written approval by the Administrator. All programming

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changes or upgrades to an approved payout device shall also receive prior written approval by the Administrator.

- c) For purposes of Section 20 of the Act, a player seeking to redeem a ticket dispensed by a video gaming terminal for cash may either:
  - 1) submit the ticket for full payment directly to a payout device; or
  - 2) submit the ticket for full payment to an authorized employee of the licensed video gaming location who is at least 21 years old who shall then submit the ticket into a payout device.
- d) If a video gaming terminal and/or payout device has malfunctioned or is otherwise inoperable and unable to produce a ticket or redeem a ticket, a player shall promptly receive a "facility-pay" from an employee of the licensed video gaming location or an employee of the licensed terminal operator who is at least 21 years old.
- e) All facility payments must be accounted for by the licensed terminal operator and licensed video gaming location using Generally Accepted Accounting Principles (GAAP). This shall require, at a minimum, that each licensed video gaming location shall record the following for each facility payment:
  - 1) date and time of the payment event;
  - 2) amount paid;
  - 3) video gaming terminal license number, payout device number, or video gaming ticket number for which payment is made; and
  - 4) name of the individual processing the facility payment.
- f) A payout device may allow for automated teller machine (ATM) functionality for patron cash withdrawals initiated from bank cards and other similar instruments only when the material components of that functionality and any accompanying remote access communication is physically and logically segregated from the functionality for the video gaming ticket payment system. The ATM system and video gaming ticket payment system may share a single currency dispenser.

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- g) Each approved payout device shall:
- 1) ensure against manipulation, alteration or change of the approved payout device;
  - 2) be operated in such a manner as to cause immediate notification to the central communication system of any malfunction that affects the integrity of the approved payout device;
  - 3) provide for on-line real-time monitoring; and
  - 4) be subject to testing by an independent laboratory and review by the Board as deemed necessary or appropriate to ensure the continued integrity of the approved payout device or any of its component parts.

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 1800.1420 Redemption of Tickets Following Removal or Unavailability of Ticket Payout Devices**

- a) If a licensed video gaming location changes terminal operator providers, and/or changes ticket payout systems, such that unredeemed tickets issued under the previous terminal operator or ticket payout system are no longer redeemable by the new ticket payout device at the licensed video gaming location, the licensed video gaming location shall provide facility payments to the patrons for the tickets issued under the previous terminal operator.
- b) If a licensed video gaming location closes or ceases doing business, ceases its video gaming operation, changes locations, has its video gaming license or liquor license suspended or revoked, or is otherwise unavailable or inaccessible for patrons to redeem unredeemed tickets for more than 10 consecutive days, the licensed video gaming location shall:
- 1) place a sign prominently at the location (so long as the video gaming location licensee still has possession or control of the location) no less than 21 x 13" that reasonably informs patrons of the name and phone number of the terminal operator from which patrons can seek payment for unredeemed tickets; and

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- 2) prominently post a notice on any internet site and/or social media outlet under its operation or control that reasonably informs patrons of the name and phone number of the terminal operator from which patrons can seek payment for unredeemed tickets.
- c) When patrons cannot redeem outstanding tickets of a terminal operator at the video gaming location from which they were issued because of the reasons stated in subsection (a) or (b), the terminal operator shall promptly maintain and secure a list or database of all issued and unredeemed tickets from the video gaming location. The list or database must be maintained for no less than one year.

(Source: Added at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

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- 1) Heading of the Part: Riverboat Gambling
- 2) Code Citation: 86 Ill. Adm. Code 3000
- 3) 

<u>Section Numbers</u> :	<u>Proposed Action</u> :
3000.100	Amendment
3000.600	Amendment
3000.640	Amendment
- 4) Statutory Authority: Authorized by the Riverboat Gambling Act [230 ILCS 10], specifically Sections 5 (c) (2), (3), (6), (7), and (8) of this Act [230 ILCS 10/5 (c) (2), (3), (6), (7), and (8)]
- 5) A Complete Description of the Subjects and Issues Involved: The rulemaking makes the following changes to the Part:

Inclusion of unredeemed vouchers as part of adjusted gross receipts. The proposed rulemaking adds a definition of "adjusted gross receipts" to Section 100 of the Part (Definitions). Under the new definition, "adjusted gross receipts" are defined as gross receipts less winnings paid to wagerers. The definition further provides that the value of expired vouchers shall be included in computing adjusted gross receipts. Including the value of expired vouchers as part of adjusted gross receipts conforms with standard accounting practice in the gaming industry.

Printing of vouchers at a cashier cage. Sections 100 and 640 of the Part (Definitions), (Exchange of Chips, Tokens, and Vouchers) currently authorize the issuance of vouchers solely by means of a voucher printer connected to an electronic gaming device. In keeping with the practice at some casinos, the proposed rulemaking change will amend these sections to allow vouchers also to be printed at a cashier cage.

Use of promotional coupons. This proposed change to Section 600 authorizes the use of promotional coupons in connection with table games and deletes current language allowing the use of match play coupons. The difference between a match play coupon and a promotional coupon is that a match play coupon must be used in conjunction of the play of a chip, whereas a promotional coupon may be used in place of a chip. Under the proposed rulemaking, promotional coupons may only be used as wagers as set forth in an owner licensee's Internal Control System.

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- 6) Published studies and reports, and underlying sources of data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this proposed rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
3000.140	Amended	37 Ill. Reg. 1837; February 15, 2013
3000.614	Amended	37 Ill. Reg. 1837; February 15, 2013

- 11) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate under the State Mandates Act [30 ILCS 805].
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Any interested person may submit comments in writing concerning this proposed rulemaking not later than 45 days after publication of this Notice in the *Illinois Register* to:

Emily Mattison  
General Counsel  
Illinois Gaming Board  
160 North LaSalle Street  
Chicago, Illinois 60601

Phone: 312/814-7137  
Fax: 312/814-7253  
e-mail: emily.mattison@igb.illinois.gov

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: None

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- B) Reporting, bookkeeping or other procedures required for compliance: The proposed rulemaking will impose no additional requirements.
- C) Types of Professional skills necessary for compliance: The proposed rulemaking will impose no additional requirements.
- 14) Regulatory agenda on which this rulemaking was summarized: This rulemaking was not summarized in a regulatory agenda because the Board did not anticipate the need for rulemaking at the time the previous two agendas were published.

The full text of the Proposed Amendments begins on the next page:

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TITLE 86: REVENUE  
CHAPTER IV: ILLINOIS GAMING BOARDPART 3000  
RIVERBOAT GAMBLING

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3000.100	Definitions
3000.101	Invalidity
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3000.200	Classification of Licenses
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3000.224	Economic Disassociation
3000.225	Business Entity and Personal Disclosure Filings
3000.230	Owner's Licenses
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3000.234	Acquisition of Ownership Interest By Institutional Investors
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3000.236	Owner's License Renewal
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3000.238	Appointment of Receiver for an Owner's License
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3000.243	Bankruptcy or Change in Ownership of Supplier
3000.244	Surrender of Supplier's License
3000.245	Occupational Licenses
3000.250	Transferability of Licenses
3000.260	Waiver of Requirements
3000.270	Certification and Registration of Electronic Gaming Devices
3000.271	Analysis of Questioned Electronic Gaming Devices
3000.272	Certification of Voucher Systems
3000.280	Registration of All Gaming Devices
3000.281	Transfer of Registration (Repealed)
3000.282	Seizure of Gaming Devices (Repealed)
3000.283	Analysis of Questioned Electronic Gaming Devices (Repealed)
3000.284	Disposal of Gaming Devices
3000.285	Certification and Registration of Voucher Validation Terminals

## SUBPART C: OWNER'S INTERNAL CONTROL SYSTEM

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3000.300	General Requirements – Internal Control System
3000.310	Approval of Internal Control System
3000.320	Minimum Standards for Internal Control Systems
3000.330	Review of Procedures (Repealed)
3000.340	Operating Procedures (Repealed)
3000.350	Modifications (Repealed)

## SUBPART D: HEARINGS ON NOTICE OF DENIAL,

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RESTRICTION OF LICENSE, PLACEMENT ON BOARD EXCLUSION LIST OR  
REMOVAL FROM BOARD EXCLUSION LIST OR SELF-EXCLUSION LIST

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3000.400	Coverage of Subpart
3000.405	Requests for Hearings
3000.410	Appearances
3000.415	Discovery
3000.420	Motions for Summary Judgment
3000.424	Subpoena of Witnesses
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3000.430	Evidence
3000.431	Prohibition on Ex Parte Communication
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3000.440	Transmittal of Record and Recommendation to the Board
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## SUBPART E: CRUISING

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3000.500	Riverboat Cruises
3000.510	Cancelled or Disrupted Cruises

## SUBPART F: CONDUCT OF GAMING

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3000.600	Wagering Only with Electronic Credits, Approved Chips, Tokens and Electronic Cards
3000.602	Disposition of Unauthorized Winnings
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3000.635	Issuance and Use of Tokens for Gaming
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3000.650	Inventory of Chips
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3000.660	Minimum Standards for Electronic Gaming Devices
3000.661	Minimum Standards for Voucher Systems
3000.665	Integrity of Electronic Gaming Devices
3000.666	Bill Validator Requirements
3000.667	Integrity of Voucher Systems
3000.670	Computer Monitoring Requirements of Electronic Gaming Devices
3000.671	Computer Monitoring Requirements of Voucher Systems

## SUBPART G: EXCLUSION OF PERSONS

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3000.745	Voluntary Self-Exclusion Policy
3000.750	Establishment of a Self-Exclusion List
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3000.770	Duties of Licensees
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3000.1105	Duty to Maintain Suitability
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3000.1150	Sanctions and Penalties
3000.1155	Transmittal of Record and Recommendation to the Board

AUTHORITY: Implementing and authorized by the Riverboat Gambling Act [230 ILCS 10].

SOURCE: Emergency rule adopted at 15 Ill. Reg. 11252, effective August 5, 1991, for a maximum of 150 days; adopted at 15 Ill. Reg. 18263, effective December 10, 1991; amended at 16 Ill. Reg. 13310, effective August 17, 1992; amended at 17 Ill. Reg. 11510, effective July 9, 1993; amended at 20 Ill. Reg. 5814, effective April 9, 1996; amended at 20 Ill. Reg. 6280, effective April 22, 1996; emergency amendment at 20 Ill. Reg. 8051, effective June 3, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 14765, effective October 31, 1996; amended at 21 Ill. Reg. 4642, effective April 1, 1997; emergency amendment at 21 Ill. Reg. 14566, effective October 22, 1997, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 978, effective December 29, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 4390, effective February 20, 1998; amended at 22 Ill. Reg. 10449, effective May 27, 1998; amended at 22 Ill. Reg. 17324, effective September 21, 1998; amended at 22 Ill. Reg. 19541, effective October 23, 1998; emergency amendment at 23 Ill. Reg. 8191, effective July 2, 1999 for a maximum of 150 days; emergency expired November 28, 1999; amended at 23 Ill. Reg. 8996, effective August 2, 1999; amended at 24 Ill. Reg. 1037, effective January 10, 2000; amended at 25 Ill. Reg. 94, effective January 8, 2001; amended at 25 Ill. Reg. 13292, effective October 5, 2001; proposed amended at 26 Ill. Reg. 9307, effective June 14, 2002; emergency amendment adopted at 26 Ill. Reg. 10984, effective July 1, 2002, for a maximum of 150 days; adopted at 26 Ill. Reg. 15296, effective October 11, 2002; amended at 26 Ill. Reg. 17408, effective November 22, 2002; emergency amendment at 27 Ill. Reg. 10503, effective June 30, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 15793, effective September 25, 2003; amended at 27 Ill. Reg. 18595, effective November 25, 2003; amended at 28 Ill. Reg. 12824, effective August 31, 2004; amended at 31 Ill. Reg. 8098, effective June 14, 2007; amended at 32 Ill. Reg. 2967,

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effective February 15, 2008; amended at 32 Ill. Reg. 3275, effective February 19, 2008; amended at 32 Ill. Reg. 7357, effective April 28, 2008; amended at 32 Ill. Reg. 8592, effective May 29, 2008; amended at 32 Ill. Reg. 8931, effective June 4, 2008; amended at 32 Ill. Reg. 13200, effective July 22, 2008; amended at 32 Ill. Reg. 17418, effective October 23, 2008; amended at 32 Ill. Reg. 17759, effective October 28, 2008; amended at 32 Ill. Reg. 17946, effective November 5, 2008; amended at 34 Ill. Reg. 3285, effective February 26, 2010; amended at 34 Ill. Reg. 3748, effective March 11, 2010; amended at 34 Ill. Reg. 4768, effective March 16, 2010; amended at 34 Ill. Reg. 5200, effective March 24, 2010; amended at 34 Ill. Reg. 15386, effective September 23, 2010; amended at 36 Ill. Reg. 13199, effective July 31, 2012; amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

## SUBPART A: GENERAL PROVISIONS

**Section 3000.100 Definitions**

For purposes of this Part the following terms shall have the following meanings:

"Act": The Riverboat Gambling Act [230 ILCS 10].

"Adjusted Gross Receipts": The gross receipts less winnings paid to wagerers. The value of expired vouchers shall be included in computing adjusted gross receipts.

"Affiliate": An "Affiliate of", or person "Affiliated with", a specified person shall mean a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, such person.

"Alcoholic Liquors": Includes alcohol, spirits, wine and beer, and every liquid or solid, patented or not, containing alcohol, spirits, wine or beer, and capable of being consumed as a beverage by a human being.

"Attributed Interest": A direct or indirect interest in a Business Entity deemed to be held by a person not through the person's actual holdings but either through the holdings of the person's relatives or through a third party or parties on behalf of the person pursuant to a plan, arrangement or agreement.

"Bill Validator": Any electro-mechanical device attached either on or into an Electronic Gaming Device which accepts and analyzes the legitimacy of United States currency and/or Vouchers, validates the currency and/or Vouchers, stores

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the currency and/or Vouchers, and issues Electronic Credits equal to the value of currency and/or Vouchers inserted into the device.

"Board": The Illinois Gaming Board.

"Business Entity": A partnership, incorporated or unincorporated association or group, firm, corporation, limited liability company, partnership for shares, trust, sole proprietorship or other business enterprise.

"Chip": A non-metal or partly metal representative of value, redeemable for cash, and issued and sold by a holder of an Owner's license for use in Gaming other than in Electronic Gaming Devices on such holder's Riverboat or Riverboats.

"Chip Float": The difference between the total face value of Chips received from vendors and the total face value of Chips accounted for through an inventory conducted by the Riverboat Gaming Operation.

"Computer Monitoring System": The gaming related system used to provide on-line, real-time monitoring of Electronic Gaming Devices and data acquisition capability in the format and media approved by the Administrator.

"Dependent": Any individual who received over half of his support in a calendar year from any other individual.

"Electronic Card": A card purchased from a holder of an Owner's license for use on that holder's Riverboat Gaming Operation as a substitute for Tokens in the conduct of gaming on an Electronic Gaming Device.

"Electronic Credit": A value owed to a patron on an Electronic Gaming Device.

"Electronic Gaming Device": Includes as approved Games under Section 3000.605 Single- and Multiple-Position Reel-Type, Single- and Multiple-Position Single-Game Video and Single- and Multiple-Position Multi-Game Video Electronic Gaming Devices.

"Electronic Gaming Device Drop": The total face value of Tokens or representations of Tokens (including without limitation foreign Tokens and slugs) collected from the drop bucket and United States currency and/or Vouchers collected from the Bill Validator drop box.

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"Electronic Gaming Device Win": The Electronic Gaming Device Drop minus hand-paid jackpots minus hopper fills minus Vouchers issued.

"EPROM": An acronym for Erasable, Programmable, Read Only Memory, which is a microprocessor component that stores memory and affects payout percentage and/or contains a random number generator that selects the outcome of a Game on an Electronic Gaming Device.

"Excluded Person": Any person whose name appears on any Exclusion List, or any person whose name does not appear on an Exclusion List but who is excluded or ejected pursuant to Section 5(c)(12) of the Act or as a result of meeting one or more of the criteria in Section 3000.720 of this Part.

"Exclusion List": A list or lists which contain the identities of persons who are to be excluded or ejected from any licensed Gaming operation in any jurisdiction. The list may include any person whose reputation or conduct is such that his presence within a Riverboat Gaming Operation may, in the opinion of the Board or the Administrator, call into question the honesty or integrity of the Gaming operation or pose a threat to the interests of the State of Illinois.

"Expiration Date": The one-year period, starting on the day of issuance, during which Vouchers may be redeemed for United States currency at a [cashier](#) ~~cashier's~~ cage of a Riverboat Gaming Operation.

"Game": A gambling activity which is played for money, property, or anything of value, including without limitation those played with cards, Chips, Tokens, dice, implements, or electronic, electrical, or mechanical devices or machines.

"Gaming": The dealing, operating, carrying on, conducting, maintaining or exposing for play of any Game.

"Gaming Equipment/Supplies": A machine, mechanism, device, or implement which is integral to the operation of a Game or affects the result of a Game by determining win or loss, including without limitation: electronic, electrical, or mechanical devices or machines; cards or dice; layouts for Live Gaming Devices; any representative of value used with any Game, including without limitation Chips, Tokens, or Electronic Cards; Voucher Systems; Voucher Printers; Voucher Validation Terminals; Computer Monitoring Systems; and hardware and software

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related to any item described herein.

"Gaming Operations Manager": A person or business entity other than the holder of an Owner's license who has the ultimate responsibility to manage, direct or administer the conducting of Gaming.

"Hand": Either one Game in a series, one deal in a card Game, or the cards held by a player.

"Indirect Interest": An interest in a Business Entity that is deemed to be held by the holder of an Owner's license not through the holder's actual holdings in the business entity but through the holder's holdings in other business entities.

"Institutional Investor": A "qualified institutional buyer" as defined by Securities and Exchange Commission Rule 144A (17 CFR 230.144A) under the Securities Act of 1933, as amended.

"Internal Control System": Proprietary internal procedures and administration and accounting controls designed by the holder of an Owner's license for the purpose of exercising control over the Riverboat Gaming Operation.

"Junketeer": A person or entity that facilitates a patron's participation in gaming at a Riverboat Gaming Operation and is compensated, not as an employee but as an independent contractor, by that Operation based upon how much the patron actually wagers or loses.

"Key Person": A Person identified by the Board under Section 3000.222 as subject to regulatory approval as a Person able to control, or exercise significant influence over, the management, assets, or operating policies of an owner or supplier licensee.

"Live Gaming Device": Any apparatus, other than an Electronic Gaming Device, upon which Gaming is conducted or which determines an outcome which is the object of a wager. This definition includes but is not limited to roulette wheels, keno machines, punchboard tickets and tables with layouts utilized in Games approved by the Board.

"Marketing Agent": A person or entity, other than a junketeer or an employee of a Riverboat Gaming Operation, who is compensated by the Riverboat Gaming

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Operation in excess of \$100 per patron per trip for identifying and recruiting patrons.

"Non-Alterable Storage Media": An electronic storage medium that contains the program files that operate the game, which medium cannot be altered through the use of the circuitry or programming of the gaming device.

"Non-Value Chip": A Chip, clearly and permanently impressed, engraved or imprinted with the name of the Riverboat Gaming Operation, but bearing no value designation.

"Notice of Board Action": A Notice of Denial, Restriction, Suspension, Revocation, Nonrenewal, Fine, Exclusion or other action issued by the Board.

"Parent Company": A "parent company" of a specified person is an affiliate controlling such person directly, or indirectly through one or more intermediaries.

"Payout": Winnings earned on a wager.

"Person": "Person" includes both individuals and Business Entities.

"Petitioner": An applicant, licensee, or Excluded Person who requests a hearing upon issuance of a Notice of Board Action.

"Progressive Controller": The hardware and software that controls all communications among the machines within a progressive Electronic Gaming Device link and its associated progressive meter.

"Progressive Jackpot": An award for winning play in a Game, the value of which is determined by the contribution of a portion of each Wager placed into play or the combined amount of several wagers linked to a common jackpot award.

"Redemption Period": The 120-day period during which a Voucher may be used to acquire electronic credits from an Electronic Gaming Device or to obtain United States currency from a Voucher Validation Terminal. After their Redemption dates and prior to their Expiration dates, Vouchers may be redeemed for United States currency only at a cashier cage of a Riverboat Gaming Operation.

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"Relative": Spouse, parents, grandparents, children, siblings, uncles, aunts, nephews, nieces, fathers-in-law, mothers-in-law, sons-in-law, daughters-in-law, brothers-in-law, and sisters-in-law, whether by the whole or half blood, by marriage, adoption or natural relationship, and Dependents.

"Remote Access": Communication with an electronic information system from a remote location or facility through a data link.

"Riverboat": A navigable vessel or a permanently moored vessel comprised of one or more barges that are permanently attached to operate as one barge.

"Riverboat Gaming Operation": The owner licensee, Gaming Operations Manager, or, as the context requires, the conducting of Gaming and all related activities, including without limitation the purveying of food, beverages, retail goods and services, and transportation, on a Riverboat and at its Support Facilities.

"Signature": The definitive identity of an individual specific EPROM chip or other non-alterable storage media, determined by electronic analysis and reflective of the EPROM chip's game behavior capability.

"Substantial Owner": A person who has an ownership interest of 25% or more in a Business Entity.

"Supplier": A provider of Gaming Equipment/Supplies, Gaming Equipment maintenance or repair services, security services or a lessor of a Riverboat or dock facility.

"Support Facility": A place of business which is part of, or operates in conjunction with, a Riverboat Gaming Operation and is owned in whole or in part by a holder of an Owner's or Supplier's license or any of their Key Persons, including without limitation Riverboats, offices, docking facilities, parking facilities, and land-based hotels or restaurants.

"Table Drop": The total amount of cash or cash equivalents contained in the drop box for Chips purchased at a Live Gaming Device.

"Table Win": The dollar amount won by the holder of an Owner's license through play at a live Game which is the total of the Table Drop plus ending Chip

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inventory plus credits minus opening Chip inventory minus fills.

"Theoretical Payout Percentage": The percentage of Tokens or Electronic Credits from amounts wagered that will be returned to players by an Electronic Gaming Device.

"Token": A metal representative of value, redeemable for cash only at the issuing Riverboat Gaming Operation, and issued and sold by a holder of an Owner's license for use in Gaming.

"Token Dispenser": Any mechanical or electrical device designed for the purpose of dispensing an amount of Tokens equal to the amount of currency inserted into the device.

"Token Float": The difference between the total face value of Tokens received from vendors and the total face value of Tokens accounted for through an inventory conducted by the Riverboat Gaming Operation.

"Tournament EPROM": A specially designed EPROM with a mode of play that provides for a mathematically demonstrable payout of more than 100 percent.

"Value Chip": A Chip, clearly and permanently impressed, engraved or imprinted with the name of the Riverboat Gaming Operation and the specific value of the Chip.

"Voucher": A printed paper scrip representing the value in United States currency stated on the face of the scrip that is issued by a Voucher Printer connected to an Electronic Gaming Device or at a cashier cage at a Riverboat Gaming Operation and which scrip is redeemable for electronic credits or United States currency and is not a coupon or other promotional item.

"Voucher Float": The difference between the total face value of unexpired Vouchers issued by a Riverboat Gaming Operation and the total face value of Vouchers accounted for by the Riverboat Gaming Operation as redeemed or expired.

"Voucher Printer": A device designed for the purpose of issuing Vouchers at Electronic Gaming Devices or at a cashier cage at a Riverboat Gaming Operation.

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"Voucher System": The hardware and software used to issue and validate Vouchers, record redemptions and account for Vouchers.

"Voucher Validation Terminal": A hard-wired and interfaced device that accepts Vouchers and communicates the Voucher information to the Voucher System for the System to validate the information. If the System confirms that the Voucher is valid, the terminal then stores the Voucher and issues United States currency equal to the value of the Voucher.

"Wager": A sum of money or thing of value risked.

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## SUBPART F: CONDUCT OF GAMING

**Section 3000.600 Wagering Only with Electronic Credits, Approved Chips, Tokens and Electronic Cards**

- a) Except as provided in ~~subsections (b) and (c) of this Section~~, Riverboat Gaming Wagers may be made only with Electronic Credits, Tokens, ~~or~~ Chips or promotional coupons issued by the holder of an Owner's license and approved by the Administrator. All Chips, Tokens and Electronic Cards must be approved by the Administrator and purchased from the holder of an Owner's license. Chips, Tokens or Electronic Cards may only be used as set forth in the owner licensee's Internal Control System. Promotional coupons may only be used as wagers as set forth in the Owner's licensee's Internal Control System. At the patron's option, Electronic Credits may either be used as a Wager on an Electronic Gaming Device or be withdrawn only in the form of Tokens and/or a Voucher issued from the Electronic Gaming Device.
- b) Riverboat Gaming Wagers may be made with Electronic Credits downloaded from an owner licensee's computer management system or acquired through the insertion of a Voucher issued by an Electronic Gaming Device authorized for wagering at a holder of an Owner's license or acquired through insertion of a coupon redeemable for complimentary electronic credits, as set forth in the Owner licensee's Internal Control System.
  - 1) Prior to the Redemption Period, Vouchers may, at the patron's option, be:

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- A) used to obtain electronic credits to place a wager in Electronic Gaming Devices registered with the Board;
  - B) withdrawn only in the form of Tokens or Vouchers from the Electronic Gaming Device; or
  - C) redeemed only for United States currency at a Voucher Validation Terminal or at the cage of a holder of an Owner's license.
- 2) At any time prior to the Expiration Date, Vouchers may be redeemed for United States currency at the cage of a holder of an Owner's license.

~~e) Riverboat Gaming Wagers may be made with match play coupons issued by the holder of an Owner's license and approved by the Administrator. Match play coupons may only be used in conjunction with the Wager of a Chip as set forth in the owner licensee's Internal Control System.~~

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 3000.640 Exchange of Chips, Tokens, and Vouchers**

- a) Chips shall be issued to a person only at the request of such person and shall not be given as change in any other transaction. Chips shall only be issued to Riverboat patrons at ~~cashier~~ ~~cashier's~~ cages or at the Live Gaming Devices and shall be redeemed only at a ~~cashier~~ ~~cashier's~~ cage.
  - b) Tokens shall only be issued upon the request of a patron from a ~~cashier~~ ~~cashier's~~ cage, Token Dispenser or from employees of the holder of an Owner's license at the Electronic Gaming Device area. Tokens shall be redeemed only at a ~~cashier~~ ~~cashier's~~ cage.
  - c) Vouchers shall only be issued by approved Voucher Printers in Electronic Gaming Devices or at a cashier cage.
- 1) Prior to their Redemption Dates, Vouchers may be redeemed for:
- A) Electronic Credit at Electronic Gaming Devices, which Credit may then be redeemed as a new Voucher or in Tokens, for EGDs equipped for Tokens; and

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- B) United States currency at Voucher Validation Terminals and a cashier cage at the holder of an Owner's license.
- 2) After their Redemption Dates and prior to their Expiration Dates, Vouchers may be redeemed for United States currency only at a cashier cage of the holder of an Owner's license.
- d) Chips, Tokens, or Vouchers shall only be redeemed by a holder of an Owner's license from its patrons and shall not be knowingly redeemed from any non-patron source, except where:
- 1) employees of the holder present for redemption Chips or Tokens as provided in the approved Internal Control System of the holder;
  - 2) another holder of an Owner's License presents for redemption Tokens which have been lawfully received by that holder;
  - 3) subject to approval by the Administrator, a person licensed to conduct Gaming in another jurisdiction presents for redemption Tokens which have been lawfully received by that person; or
  - 4) the prior written approval for the redemption of the Chips or Tokens is obtained in each instance from the Administrator.
- e) Each Riverboat shall promptly redeem its own Chips, Tokens and Vouchers by cash or by check dated the day of such redemption on an account of the Riverboat, as requested by the patron, except when the Chips, Tokens and Vouchers were obtained or used unlawfully.
- f) Each Riverboat may demand the redemption of its Chips, Tokens or Vouchers from any person in possession of them and that person shall redeem the Chips, Tokens or Vouchers upon presentation by the Riverboat Gaming Operation of an equivalent amount of cash or check dated the same day on an account of the Riverboat.
- g) Each Riverboat shall cause to be posted and remain posted in a prominent place:
- 1) On the front of a ~~cashier~~ cashier's-cage a sign that reads as follows:

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"Gaming Chips, Tokens or Vouchers issued by another Riverboat may not be used, exchanged or redeemed in this Riverboat";

- 2) On Electronic Gaming Device Token redemption booths a sign that reads as follows: "Tokens or Vouchers issued by another Riverboat may not be used, exchanged or redeemed in this Riverboat"; and
- 3) On Voucher Validation Terminals a sign that reads as follows: "Vouchers issued by another Riverboat may not be used, exchanged or redeemed in this Riverboat".

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

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- 1) Heading of the Part: Hospital Services
- 2) Code Citation: 89 Ill. Adm. Code 148
- 3) Section Number: 148.140                      Proposed Action: Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Complete Description of the Subjects and Issues Involved: The proposed amendment provides for an add-on payment to hospitals and freestanding chronic dialysis centers for outpatient renal dialysis treatments or home dialysis treatments by \$60 per treatment day. The add-on payment is effective with services provided on and after July 1, 2013.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does affect units of local government. It will have an impact on government-owned or government-operated hospitals.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue E., 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

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217/782-1233  
HFS.Rules@illinois.gov

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: Free-standing chronic dialysis centers
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of Professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this Rulemaking was Summarized: The need for this rulemaking was not anticipated by the Department when the most recent regulatory agenda was published.

The full text of the Proposed Rulemaking begins on the next page:

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TITLE 89: SOCIAL SERVICES  
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
SUBCHAPTER d: MEDICAL PROGRAMSPART 148  
HOSPITAL SERVICES

## SUBPART A: GENERAL PROVISIONS

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148.10	Hospital Services
148.20	Participation
148.25	Definitions and Applicability
148.30	General Requirements
148.40	Special Requirements
148.50	Covered Hospital Services
148.60	Services Not Covered as Hospital Services
148.70	Limitation On Hospital Services

## SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section	
148.80	Organ Transplants Services Covered Under Medicaid (Repealed)
148.82	Organ Transplant Services
148.85	Supplemental Tertiary Care Adjustment Payments
148.90	Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments
148.95	Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments
148.100	Outpatient Rural Hospital Adjustment Payments
148.103	Outpatient Service Adjustment Payments
148.105	Psychiatric Adjustment Payments
148.110	Psychiatric Base Rate Adjustment Payments
148.112	High Volume Adjustment Payments
148.115	Rural Adjustment Payments
148.117	Outpatient Assistance Adjustment Payments
148.120	Disproportionate Share Hospital (DSH) Adjustments
148.122	Medicaid Percentage Adjustments
148.126	Safety Net Adjustment Payments
148.130	Outlier Adjustments for Exceptionally Costly Stays
148.140	Hospital Outpatient and Clinic Services

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- 148.150 Public Law 103-66 Requirements
- 148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million
- 148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act
- 148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act
- 148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting
- 148.190 Copayments
- 148.200 Alternate Reimbursement Systems
- 148.210 Filing Cost Reports
- 148.220 Pre September 1, 1991, Admissions
- 148.230 Admissions Occurring on or after September 1, 1991
- 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
- 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
- 148.260 Calculation and Definitions of Inpatient Per Diem Rates
- 148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals
- 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements
- 148.285 Excellence in Academic Medicine Payments (Repealed)
- 148.290 Adjustments and Reductions to Total Payments
- 148.295 Critical Hospital Adjustment Payments (CHAP)
- 148.296 Tertiary Care Adjustment Payments
- 148.297 Pediatric Outpatient Adjustment Payments
- 148.298 Pediatric Inpatient Adjustment Payments
- 148.300 Payment
- 148.310 Review Procedure
- 148.320 Alternatives
- 148.330 Exemptions
- 148.340 Subacute Alcoholism and Substance Abuse Treatment Services
- 148.350 Definitions (Repealed)
- 148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
- 148.368 Volume Adjustment (Repealed)
- 148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services

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- 148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
- 148.390 Hearings
- 148.400 Special Hospital Reporting Requirements
- 148.402 Medicaid Eligibility Payments (Repealed)
- 148.404 Medicaid High Volume Adjustment Payments (Repealed)
- 148.406 Intensive Care Adjustment Payments (Repealed)
- 148.408 Trauma Center Adjustment Payments (Repealed)
- 148.410 Psychiatric Rate Adjustment Payments (Repealed)
- 148.412 Rehabilitation Adjustment Payments (Repealed)
- 148.414 Supplemental Tertiary Care Adjustment Payments (Repealed)
- 148.416 Crossover Percentage Adjustment Payments (Repealed)
- 148.418 Long Term Acute Care Hospital Adjustment Payments (Repealed)
- 148.420 Obstetrical Care Adjustment Payments (Repealed)
- 148.422 Outpatient Access Payments (Repealed)
- 148.424 Outpatient Utilization Payments (Repealed)
- 148.426 Outpatient Complexity of Care Adjustment Payments (Repealed)
- 148.428 Rehabilitation Hospital Adjustment Payments (Repealed)
- 148.430 Perinatal Outpatient Adjustment Payments (Repealed)
- 148.432 Supplemental Psychiatric Adjustment Payments (Repealed)
- 148.434 Outpatient Community Access Adjustment Payments (Repealed)
- 148.440 High Volume Adjustment Payments
- 148.442 Inpatient Services Adjustment Payments
- 148.444 Capital Needs Payments
- 148.446 Obstetrical Care Payments
- 148.448 Trauma Care Payments
- 148.450 Supplemental Tertiary Care Payments
- 148.452 Crossover Care Payments
- 148.454 Magnet Hospital Payments
- 148.456 Ambulatory Procedure Listing Increase Payments
- 148.458 General Provisions
- 148.460 Catastrophic Relief Payments
- 148.462 Hospital Medicaid Stimulus Payments

## SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

- Section
- 148.500 Definitions
- 148.510 Reimbursement

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## SUBPART D: STATE CHRONIC RENAL DISEASE PROGRAM

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148.610	Scope of the Program
148.620	Assistance Level and Reimbursement
148.630	Criteria and Information Required to Establish Eligibility
148.640	Covered Services

## SUBPART E: INSTITUTION FOR MENTAL DISEASES PROVISIONS FOR HOSPITALS

Section	
148.700	General Provisions

## SUBPART F: EMERGENCY PSYCHIATRIC DEMONSTRATION PROGRAM

Section	
148.800	General Provisions
148.810	Definitions
148.820	Individual Eligibility for the Program
148.830	Providers Participating in the Program
148.840	Stabilization and Discharge Practices
148.850	Medication Management
148.860	Community Connect IMD Hospital Payment
148.870	Community Connect TCM Agency Payment
148.880	Program Reporting
148.TABLE A	Renal Participation Fee Worksheet
148.TABLE B	Bureau of Labor Statistics Equivalence
148.TABLE C	List of Metropolitan Counties by SMSA Definition

**AUTHORITY:** Implementing and authorized by Articles III, IV, V and VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

**SOURCE:** Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg.

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15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency expired July 29, 1995; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective November 28, 1995; amended at 20 Ill. Reg. 872, effective December 29, 1995; amended at 20 Ill. Reg. 7912, effective May 31, 1996; emergency amendment at 20 Ill. Reg. 9281, effective July 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 12510, effective September 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15722, effective November 27, 1996; amended at 21 Ill. Reg. 607, effective January 2, 1997; amended at 21 Ill. Reg. 8386, effective June 23, 1997; emergency amendment at 21 Ill. Reg. 9552, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9822, effective July 2, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 10147, effective August 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13349, effective September 23, 1997; emergency amendment at 21 Ill. Reg. 13675, effective September 27, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16161, effective November 26, 1997; amended at 22 Ill. Reg. 1408, effective December 29, 1997; amended at 22 Ill. Reg. 3083, effective January 26, 1998; amended at 22 Ill. Reg. 11514, effective June 22, 1998; emergency amendment at 22 Ill. Reg. 13070, effective July 1, 1998, for a maximum of 150 days; emergency

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amendment at 22 Ill. Reg. 15027, effective August 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16273, effective August 28, 1998; amended at 22 Ill. Reg. 21490, effective November 25, 1998; amended at 23 Ill. Reg. 5784, effective April 30, 1999; amended at 23 Ill. Reg. 7115, effective June 1, 1999; amended at 23 Ill. Reg. 7908, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8213, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12772, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13621, effective November 1, 1999; amended at 24 Ill. Reg. 2400, effective February 1, 2000; amended at 24 Ill. Reg. 3845, effective February 25, 2000; emergency amendment at 24 Ill. Reg. 10386, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11846, effective August 1, 2000; amended at 24 Ill. Reg. 16067, effective October 16, 2000; amended at 24 Ill. Reg. 17146, effective November 1, 2000; amended at 24 Ill. Reg. 18293, effective December 1, 2000; amended at 25 Ill. Reg. 5359, effective April 1, 2001; emergency amendment at 25 Ill. Reg. 5432, effective April 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6959, effective June 1, 2001; emergency amendment at 25 Ill. Reg. 9974, effective July 23, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 10513, effective August 2, 2001; emergency amendment at 25 Ill. Reg. 12870, effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002; amended at 25 Ill. Reg. 16087, effective December 1, 2001; emergency amendment at 26 Ill. Reg. 536, effective December 31, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 680, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 4825, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 4953, effective March 18, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 7786, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 7340, effective April 30, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 8395, effective May 28, 2002; emergency amendment at 26 Ill. Reg. 11040, effective July 1, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16612, effective October 22, 2002; amended at 26 Ill. Reg. 12322, effective July 26, 2002; amended at 26 Ill. Reg. 13661, effective September 3, 2002; amended at 26 Ill. Reg. 14808, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 14887, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17775, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 580, effective January 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 866, effective January 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 4386, effective February 24, 2003; emergency amendment at 27 Ill. Reg. 8320, effective April 28, 2003, for a maximum of 150 days; emergency amendment repealed at 27 Ill. Reg. 12121, effective July 10, 2003; amended at 27 Ill. Reg. 9178, effective May 28, 2003; emergency amendment at 27 Ill. Reg. 11041, effective July 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16185, effective October 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16268, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18843, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 1418, effective

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January 8, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 1766, effective January 10, 2004, for a maximum of 150 days; emergency expired June 7, 2004; amended at 28 Ill. Reg. 2770, effective February 1, 2004; emergency amendment at 28 Ill. Reg. 5902, effective April 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7101, effective May 3, 2004; amended at 28 Ill. Reg. 8072, effective June 1, 2004; emergency amendment at 28 Ill. Reg. 8167, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9661, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10157, effective July 1, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 12036, effective August 3, 2004, for a maximum of 150 days; emergency expired December 30, 2004; emergency amendment at 28 Ill. Reg. 12227, effective August 6, 2004, for a maximum of 150 days; emergency expired January 2, 2005; amended at 28 Ill. Reg. 14557, effective October 27, 2004; amended at 28 Ill. Reg. 15536, effective November 24, 2004; amended at 29 Ill. Reg. 861, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2026, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 5514, effective April 1, 2005; emergency amendment at 29 Ill. Reg. 5756, effective April 8, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 11622, effective July 5, 2005, for the remainder of the 150 days; amended at 29 Ill. Reg. 8363, effective June 1, 2005; emergency amendment at 29 Ill. Reg. 10275, effective July 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12568, effective August 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 15629, effective October 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19973, effective November 23, 2005; amended at 30 Ill. Reg. 383, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 955, effective January 9, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 2827, effective February 24, 2006; emergency amendment at 30 Ill. Reg. 7786, effective April 10, 2006, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 30 Ill. Reg. 12400, effective July 1, 2006, for the remainder of the 150 days; emergency expired September 6, 2006; amended at 30 Ill. Reg. 8877, effective May 1, 2006; amended at 30 Ill. Reg. 10393, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11815, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18672, effective November 27, 2006; emergency amendment at 31 Ill. Reg. 1602, effective January 1, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 1997, effective January 15, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 5596, effective April 1, 2007; amended at 31 Ill. Reg. 8123, effective May 30, 2007; amended at 31 Ill. Reg. 8508, effective June 1, 2007; emergency amendment at 31 Ill. Reg. 10137, effective July 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11688, effective August 1, 2007; amended at 31 Ill. Reg. 14792, effective October 22, 2007; amended at 32 Ill. Reg. 312, effective January 1, 2008; emergency amendment at 32 Ill. Reg. 518, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 2993, effective February 16, 2008, for a maximum of 150 days; amended at 32 Ill.

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Reg. 8718, effective May 29, 2008; amended at 32 Ill. Reg. 9945, effective June 26, 2008; emergency amendment at 32 Ill. Reg. 10517, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 33 Ill. Reg. 501, effective December 30, 2008; peremptory amendment at 33 Ill. Reg. 1538, effective December 30, 2008; emergency amendment at 33 Ill. Reg. 5821, effective April 1, 2009, for a maximum of 150 days; emergency expired August 28, 2009; amended at 33 Ill. Reg. 13246, effective September 8, 2009; emergency amendment at 34 Ill. Reg. 15856, effective October 1, 2010, for a maximum of 150 days; emergency expired February 27, 2011; amended at 34 Ill. Reg. 17737, effective November 8, 2010; amended at 35 Ill. Reg. 420, effective December 27, 2010; amended at 35 Ill. Reg. 10033, effective June 15, 2011; amended at 35 Ill. Reg. 16572, effective October 1, 2011; emergency amendment at 36 Ill. Reg. 10326, effective July 1, 2012 through June 30, 2013; emergency amendment to Section 148.70(g) suspended at 36 Ill. Reg. 13737, effective August 15, 2012; suspension withdrawn from Section 148.70(g) at 36 Ill. Reg. 18989, December 11, 2012; emergency amendment in response to Joint Committee on Administrative Rules action on Section 148.70(g) at 36 Ill. Reg. 18976, effective December 12, 2012 through June 30, 2013; emergency amendment to Section 148.140(b)(1)(F) suspended at 36 Ill. Reg. 13739, effective August 15, 2012; suspension withdrawn from Section 148.140(b)(1)(F) at 36 Ill. Reg. 14530, September 11, 2012; emergency amendment to Sections 148.140(b) and 148.190(a)(2) in response to Joint Committee on Administrative Rules action at 36 Ill. Reg. 14851, effective September 21, 2012 through June 30, 2013; amended at 37 Ill. Reg. 402, effective December 27, 2012; emergency rulemaking at 37 Ill. Reg. 5082, effective April 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. \_\_\_\_\_, effective June 27, 2013; amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

## SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

**Section 148.140 Hospital Outpatient and Clinic Services**

- a) Fee-For-Service Reimbursement
  - 1) Reimbursement for hospital outpatient services shall be made on a fee-for-service basis, except for:
    - A) Those services that meet the definition of the Ambulatory Procedure Listing (APL) as described in subsection (b) of this Section.
    - B) End stage renal disease treatment (ESRDT) services, as described in subsection (c) of this Section.

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- C) Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D).
  - D) Those services provided by a Critical Clinic Provider as described in subsection (e) of this Section.
- 2) Except for the procedures under the APL groupings described in subsection (b) of this Section, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.
- 3) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rate described in subsection (a)(2) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
- A) The reimbursement rates described in subsection (a)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
  - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 4) Maternal and Child Health Program rates, as described in 89 Ill. Adm. Code 140, Table M, shall be paid to Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A) and Section 148.25(b)(5)(A), Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code

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140.461(f)(1)(B) and Section 148.25(b)(5)(B), and Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C), and Section 148.25(b)(5)(C). Maternal and Child Health Program rates shall also be paid to Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), for covered services as described in 89 Ill. Adm. Code 140.462(e)(3), that are provided to non-assigned Maternal and Child Health Program clients, as described in 89 Ill. Adm. Code 140.464(b)(1).

- 5) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b)(2) for assigned clients.
  - 6) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
  - 7) With the exception of the retrospective adjustment described in subsection (a)(3) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this Section.
- b) Ambulatory Procedure Listing (APL)  
Effective July 1, 2012, the Department will reimburse hospitals for certain hospital outpatient procedures as described in subsection (b)(1) of this Section.
- 1) APL Groupings  
Under the APL, a list was developed that defines those technical procedures that require the use of the hospital outpatient setting, its technical staff or equipment. These procedures are separated into separate groupings based upon the complexity and historical costs of the procedures. The groupings are as follows:
    - A) Surgical Groups
      - i) Surgical group 1(a) consists of intense surgical procedures. Group 1(a) surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills

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and highly technical operating room personnel using high technology equipment. The rate for this surgical procedure group shall be \$1,794.00.

- ii) Surgical group 1(b) consists of moderately intense surgical procedures. Group 1(b) surgeries generally require the use of an operating room suite or an emergency room treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment. The rate for this surgical procedure group shall be \$1,049.00.
- iii) Surgical group 1(c) consists of low intensity surgical procedures. Group 1(c) surgeries may be done in an operating suite or an emergency room and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons. The rate for this surgical procedure group shall be \$752.00.
- iv) Surgical group 1(d) consists of surgical procedures of very low intensity. Group 1(d) surgeries may be done in an operating room or emergency room, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures. Certain dental procedures performed by dentists are included in this group. In order for a dental procedure to be eligible for reimbursement in the outpatient setting, the following criteria must be met: patient requires general anesthesia or conscious sedation; patient has a medical condition that places the patient at an increased surgical risk, such as, but not limited to, cardiopulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or the patient cannot be safely managed in an office setting because of behavioral, developmental, or mental disorder. The rate for this surgical procedure group shall be \$287.00.

## B) Diagnostic and Therapeutic Groups

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- i) Diagnostic and therapeutic group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2(a) procedures are typically invasive and must be administered by a physician. The rate for this surgical procedure group shall be \$941.00.
  - ii) Diagnostic and therapeutic group 2(b) consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2(b) procedures typically include radiological consultation or a diagnostic study. The rate for this procedure group shall be \$304.00.
  - iii) Diagnostic and therapeutic group 2(c) consists of other diagnostic tests. Group 2(c) procedures are generally non-invasive and may be administered by a technician and monitored by a physician. The rate for this procedure group shall be \$176.00.
  - iv) Diagnostic and therapeutic group 2(d) consists of therapeutic procedures. Group 2(d) procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such procedures. The rate for this procedure group shall be \$136.00.
- C) Group 3 reimbursement for services provided in a hospital emergency department will be made in accordance with one of the three levels described in this Section. Emergency Services mean those services that are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The determination of the level of service reimbursable by the Department shall be based upon the

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circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.

- i) Emergency Level I refers to Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries that pose an immediate significant threat to life or physiologic function or requires an intense level of physician or nursing intervention. An "intense level" is defined as more than two hours of documented one-on-one nursing care or interactive treatment. The rate for this service shall be \$181.00.
  - ii) Emergency Level II refers to Emergency Services that do not meet the definition in this Section of Emergency Level I care, but that are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity. The rate for this service shall be \$67.00.
  - iii) Non-Emergency/Screening Level means those services provided in the hospital emergency department that do not meet the requirements of Emergency Level I or II stated in this Section. For such care, the Department will reimburse the hospital either applicable current FFS rates for the services provided or a screening fee, but not both. The rate for this service shall be \$26.00.
- D) Group 4 for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting that provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. Observation services will be reimbursed under one of three categories:

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- i) for at least 60 minutes but less than six hours and 31 minutes of services, the rate shall be \$74.00;
  - ii) for at least six hours and 31 minutes but less than 12 hours and 31 minutes of services, the rate shall be \$222.00; or
  - iii) for at least 12 hours and 31 minutes or more of services, the rate shall be \$443.00.
- E) Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services. Under this group, the Department will reimburse, at different rates, Type A and Type B Psychiatric Clinic Services, as defined in Section 148.40(d)(1). A different rate will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
- i) The rate for Type A psychiatric clinic services shall be \$68.00.
  - ii) The rate for Type A psychiatric clinic services provided by a Children's Hospital shall be \$102.00.
  - iii) The rate for Type B psychiatric clinic services shall be \$101.00.
  - iv) The rate for Type B psychiatric clinic services provided by a Children's Hospital shall be \$102.00.
- F) Effective July 1, 2012, subject to 89 Ill. Adm. Code 152.100, Group 6 for physical rehabilitation services shall no longer be in effect and outpatient physical rehabilitation services provided by a hospital shall be reimbursed through the non-institutional payment system, but will be reimbursed as a hospital service at the following rates of reimbursement:

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- i) The rate for rehabilitation services provided by a hospital enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00.
  - ii) The rate for rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation shall be \$115.00.
  - iii) The rate for rehabilitation services provided by children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3)(A), shall be \$130.00.
- 2) Each of the groups described in subsection (b)(1) of this Section will be reimbursed by the Department considering the following:
- A) The Department will provide cost outlier payments for specific devices and drugs associated with specific APL procedures. Such payments will be made if:
    - i) The device or drug is on an approved list maintained by the Department. In order to be approved, the Department will consider requests from medical providers and shall base its decision on medical appropriateness of the device or drug and the costs of such device or drug; and
    - ii) The provision of such devices or drugs is deemed to be medically appropriate for a specific client, as determined by the Department's physician consultants.
  - B) Additional payment for such devices or drugs, as described in subsection (b)(2)(A) of this Section, will require prior authorization by the Department unless it is determined by the Department's professional medical staff that prior authorization is not warranted for a specific device or drug. When such prior authorization has been denied for a specific device or drug, the decision may be appealed as allowed by 89 Ill. Adm. Code 102.80(a)(7) and in accordance with the provisions for assistance appeals at 89 Ill. Adm. Code 104.

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- C) The amount of additional payment for devices or drugs, as described in subsection (b)(2)(A) of this Section, will be based on the following methodology:
- i) The product of a cost to charge ratio that, in the case of cost reporting hospitals as described in Section 148.130(d), or in the case of other non-cost reporting providers, equals 0.5 multiplied by the provider's total covered charges on the qualifying claim, less the APL payment rate multiplied by four;
  - ii) If the result of subsection (b)(2)(C)(i) of this Section is less than or equal to zero, no additional payment will be made. If the result is greater than zero, the additional payment will equal the result of subsection (b)(2)(C)(i) of this Section, multiplied by 80 percent. In such cases, the provider will receive the sum of the APL payment and the additional payment for such high cost devices or drugs.
- D) For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amounts described in subsection (b)(1) of this Section multiplied by a factor of 2.72.
- E) Reimbursement rates for hospitals not required to file an annual cost report with the Department may be lower than those listed in this Section.
- F) Reimbursement for each APL group described in this subsection (b) shall be all-inclusive for all services provided by the hospital, regardless of the amount charged by a hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician providing direct patient care who is salaried by the hospital; chemotherapy services provided in conjunction with radiation therapy services; and physical rehabilitation, occupational or speech therapy services

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provided in conjunction with any APL group described in this subsection (b). For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.

- 3) The assignment of procedure codes to each of the reimbursement groups in subsections (b)(1)(A) through (b)(1)(E) of this Section are detailed in the Department's Hospital Handbook and in notices to providers.
- 4) A one-time fiscal year 2000 payment will be made to hospitals. Payment will be based upon the services, specified in this Section, provided on or after July 1, 1998, and before July 1, 1999, which were submitted to the Department and determined eligible for payment (adjudicated) by the Department on or prior to April 30, 2000, excluding services for Medicare/Medicaid crossover claims and claims that resulted in a zero payment by the Department. A one-time amount of:
  - A) \$27.75 will be paid for each service for procedure code W7183 (Psychiatric clinic Type A for adults).
  - B) \$24.00 will be paid for each service for APL Group 5 (Psychiatric clinic Type A only) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
  - C) \$15.00 will be paid for each service for APL Group 6 (Physical rehabilitation services) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
- 5) County Facility Outpatient Adjustment
  - A) Effective for services provided on or after July 1, 1995, county owned hospitals in an Illinois county with a population of over three million shall be eligible for a county facility outpatient

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adjustment payment. This adjustment payment shall be in addition to the amounts calculated under this Section and are calculated as follows:

- i) Beginning with July 1, 1995, hospitals under this subsection shall receive an annual adjustment payment equal to total base year hospital outpatient costs trended forward to the rate year minus total estimated rate year hospital outpatient payments, multiplied by the resulting ratio derived when the value 200 is divided by the quotient of the difference between total base year hospital outpatient costs trended forward to the rate year and total estimated rate year hospital outpatient payments divided by one million.
  - ii) The payment calculated under this subsection (b)(5)(A) may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.
  - iii) The county facility outpatient adjustment under this subsection shall be made on a quarterly basis.
- B) County Facility Outpatient Adjustment Definition. The definitions of terms used with reference to calculation of the county facility outpatient adjustment are as follows:
- i) "Base Year" means the most recently completed State fiscal year.
  - ii) "Rate Year" means the State fiscal year during which the county facility adjustment payments are made.
  - iii) "Total Estimated Rate Year Hospital Outpatient Payments" means the Department's total estimated outpatient date of service liability, projected for the upcoming rate year.
  - iv) "Total Hospital Outpatient Costs" means the statewide sum of all hospital outpatient costs derived by summing each

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hospital's outpatient charges derived from actual paid claims data multiplied by the hospital's cost-to-charge ratio.

- 6) Critical Access Hospital Rate Adjustment  
Hospitals designated by the Illinois Department of Public Health as Critical Access Hospital (CAH) providers in accordance with 42 CFR 485.subpart F shall be eligible for an outpatient rate adjustment for services identified in subsections (b)(1)(A) through (b)(1)(F), excluding services for Medicare/Medicaid crossover claims. This adjustment shall be calculated as follows:
- A) An annual distribution factor shall be calculated as follows:
- i) The numerator shall be \$33 million.
  - ii) The denominator shall be the RY 2011 total outpatient cost coverage deficit calculated in accordance with 89 Ill. Adm. Code 148.115, less the RY 2011 Rural Adjustment Outpatient Payments calculated in accordance with 89 Ill. Adm. Code 148.115, plus the annual outpatient supplemental payment calculated in accordance with 89 Ill. Adm. Code 148.456.
- B) Hospital Specific Adjustment Value  
For each hospital qualified under this subsection (b)(6) the hospital specific adjustment value shall be the product of each hospital's specific cost coverage deficit calculated in subsection (b)(6)(A)(ii) and the distribution factor calculated in subsection (b)(6)(A):
- C) Effective for dates of service on or after July 1, 2012, the final APL Rate Adjustment Values shall be the quotient of:
- i) The hospital specific adjustment value identified in subsection (b)(6)(B) divided by
  - ii) The total outpatient services identified in subsections (b)(1)(A) through (b)(1)(E), excluding services for Medicare/Medicaid crossover claims for calendar year

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2009, adjudicated and contained in the Department's paid claims database as of December 31, 2010.

- D) **Non-State Government Owned Provider Adjustment**  
Final APL rates for hospitals identified in non-State government owned or operated providers in the State's Upper Payment Limits demonstration shall be adjusted when necessary to assure compliance with federal upper payment limits as stated in 42 CFR 447.304.
- E) **Applicability**  
The rates calculated in accordance with subsection (b)(6)(A) shall be effective for dates of service beginning January 1, 2011 and shall be adjusted each State fiscal year beginning July 1, 2011.
- i) For State fiscal year 2011, the rate year shall begin January 1, 2011 and end June 30, 2011.
- ii) For State fiscal year 2012 and beyond, the rate year shall be for dates of services beginning July 1 through June 30 of the subsequent year.
- iii) For purposes of this adjustment, a children's hospital identified in Section 149.50(c)(3)(B) shall be combined with the corresponding general acute care parent hospital.
- iv) Beginning with State fiscal year 2012 and each subsequent State fiscal year thereafter, the adjustment to the FY 2011 final APL Rate adjustment shall be limited to 2% in accordance with spending limits in 35 ILCS 5/201.5.
- 7) **No Year-End Reconciliation**  
With the exception of the retrospective rate adjustment described in subsection (b)(9) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).
- 8) **Rate Adjustments**  
With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(5) of this Section shall be

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adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

- A) The reimbursement rates described in subsection (b)(5) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
  - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 9) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals reimbursed under the Ambulatory Care Program in the same manner as to encounter rate hospitals and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.
- 10) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- c) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:
- 1) For inpatient hospital services provided pursuant to Section 148.40(c)(1), the Department shall reimburse hospitals pursuant to Sections 148.240 through 148.300 and 89 Ill. Adm. Code 149.
  - 2) For outpatient services or home dialysis treatments provided pursuant to Section 148.40(c)(2) or (c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate that will reimburse the provider for the dialysis treatment and all related supplies and equipment, as

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defined in 42 CFR 405.2163 (1994). This rate will be that rate established by Medicare pursuant to 42 CFR 405.2124 and 413.170 (1994).

- 3) Payment for non-routine services. For services that are provided during outpatient or home dialysis treatment pursuant to Section 148.40(c)(2) or (c)(3) but are not defined as a routine service under 42 CFR 405.2163 (1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.
- 4) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.
- 5) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
  - A) The reimbursement rates described in this subsection (c) shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
  - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 6) With the exception of the retrospective rate adjustment described in subsection (c)(5) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (c).
- 7) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) of this Section shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- 8) Effective July 1, 2013, hospitals and freestanding chronic dialysis centers

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will receive an add-on payment of \$60 per treatment day to the rate described in subsection (c)(2) for outpatient renal dialysis treatments or home dialysis treatments provided to Medicaid recipients under Title XIX of the Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/ Medicare crossovers) and excluding services provided under Subpart D: State Chronic Renal Disease Program, as defined in Sections 148.600 through 148.640.

- d) Non Hospital-Based Clinic Reimbursement
- 1) County-Operated Outpatient Facility Reimbursement  
Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C), that do not qualify as either a Maternal and Child Health Program managed care clinics, as described in 89 Ill. Adm. Code 140.461(f), or as a Critical Clinic Provider, as described in subsection (e) of this Section, shall be on an all-inclusive per encounter rate basis as follows:
- A) Base Rate. The per encounter base rate shall be calculated as follows:
- i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.
- ii) The resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section, shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.
- iii) The resulting product, as calculated in subsection (d)(1)(A)(ii) of this Section, shall be added to the resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section to determine the per encounter base rate.
- iv) The resulting sum, as calculated in subsection (d)(1)(A)(iii) of this Section, shall be the per encounter base rate.
- B) Supplemental Rate

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- i) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.
  - ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.
  - iii) The quotient derived in subsection (d)(1)(B)(i) of this Section shall be added to the product derived in subsection (d)(1)(B)(ii) of this Section, to determine the per encounter supplemental rate.
  - iv) The resulting sum, as described in subsection (d)(1)(B)(iii) of this Section, shall be the per encounter supplemental rate.
- C) Final Rate
- i) The per encounter base rate, as described in subsection (d)(1)(A)(iv) of this Section, shall be added to the per encounter supplemental rate, as described in subsection (d)(1)(B)(iv) of this Section, to determine the per encounter final rate.
  - ii) The resulting sum, as determined in subsection (d)(1)(C)(i) of this Section, shall be the per encounter final rate.
  - iii) The per encounter final rate, as described in subsection (d)(1)(C)(ii) of this Section, shall be adjusted in accordance with subsection (d)(2) of this Section.
- 2) Rate Adjustments
- Rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) of this Section, shall be calculated as follows:
- A) The reimbursement rates described in subsections (d)(1)(A) through (d)(1)(C) and (e)(2) of this Section shall be no less than

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the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
  - C) The final rate described in subsection (d)(1)(C) of this Section shall be no less than \$147.09 per encounter.
- 3) County-operated outpatient facilities, as described in Section 148.25(b)(2)(C), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (d).
- 4) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals reimbursed under the Ambulatory Care Program and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.
- e) Critical Clinic Providers
- 1) Effective for services provided on or after September 27, 1997, a clinic owned or operated by a county with a population of over three million, that is within or adjacent to a hospital, shall qualify as a Critical Clinic Provider if the facility meets the efficiency standards established by the Department. The Department's efficiency standards under this subsection (e) require that the quotient of total encounters per facility fiscal year for the Critical Clinic Provider divided by total full time equivalent physicians

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providing services at the Critical Clinic Provider shall be greater than:

- A) 2700 for reimbursement provided during the facility's cost reporting year ending during 1998,
  - B) 2900 for reimbursement provided during the facility's cost reporting year ending during 1999,
  - C) 3100 for reimbursement provided during the facility's cost reporting year ending during 2000,
  - D) 3600 for reimbursement provided during the facility's cost reporting year ending during 2001, and
  - E) 4200 for reimbursement provided during the facility's cost reporting year ending during 2002.
- 2) Reimbursement for all services provided by any Critical Clinic Provider shall be on an all-inclusive per-encounter rate that shall equal reported direct costs of Critical Clinic Providers for each facility's cost reporting period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.
- 3) Critical Clinic Providers, as described in this subsection (e), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (e).
- 4) The reimbursement rates described in this subsection (e) shall be no less than the reimbursement rates in effect on July 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

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- f) Critical Clinic Provider Pharmacies  
Prescribed drugs, dispensed by a pharmacy that is a Critical Clinic Provider, that are not part of an encounter reimbursable under subsection (e) of this Section shall be reimbursed at the rate described in subsection (e)(2) of this Section.

(Source: Amended at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## DEPARTMENT OF NATURAL RESOURCES

## NOTICE OF PROPOSED RULES

- 1) Heading of the Part: Off-Highway Vehicle Usage Stamps
- 2) Code Citation: 17 Ill. Adm. Code 2525
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
2525.10	New Section
2525.20	New Section
2525.30	New Section
2525.40	New Section
2525.50	New Section
- 4) Statutory Authority: Implementing and authorized by Sections 26 and 45 of the Recreational Trails of Illinois Act [20 ILCS 862/26 and 45] and Sections 11-1427.1, 11-1427.3 and 11-1427.4 of the Illinois Vehicle Code [625 ILCS 5/11-1427.1, 11-1427.3 and 11-1427.4]
- 5) A Complete Description of the Subjects and Issues Involved: This Part sets the guidelines for issuance/sale of Off-Highway Vehicle Usage Stamps. This Part also prescribes what information is collected during the sale process, and the expiration date and the display of the permits.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on the proposed rulemaking may be submitted in writing for a period of 45 days following publication of this Notice to:

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Julia Lawrence, Legal Counsel  
Department of Natural Resources  
One Natural Resources Way  
Springfield IL 62702-1271

217/782-6899

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of Professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: January 2013

The full text of the Proposed Rules begins on the next page:

## DEPARTMENT OF NATURAL RESOURCES

## NOTICE OF PROPOSED RULES

TITLE 17: CONSERVATION  
CHAPTER I: DEPARTMENT OF NATURAL RESOURCES  
SUBCHAPTER f: ADMINISTRATIVE SERVICESPART 2525  
OFF-HIGHWAY VEHICLE USAGE STAMPS

## Section

2525.10	Applicability
2525.20	Definitions
2525.30	Application for Off-Highway Vehicle Usage Stamp
2525.40	Display of Off-Highway Vehicle Usage Stamp
2525.50	Exception from Display of Off-Highway Vehicle Usage Stamp

AUTHORITY: Implementing and authorized by Sections 26 and 45 of the Recreational Trails of Illinois Act [20 ILCS 862/26 and 45] and Sections 11-1427.1, 11-1427.3 and 11-1427.4 of the Illinois Vehicle Code [625 ILCS 5/11-1427.1, 11-1427.3 and 11-1427.4].

SOURCE: Adopted at 37 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 2525.10 Applicability**

This Part governs the purchase and display of Off-Highway Vehicle Usage Stamps under the jurisdiction of the Illinois Department of Natural Resources.

**Section 2525.20 Definitions**

"Department" means the Illinois Department of Natural Resources.

"International" or "National Competition Circuit" means any competition circuit sponsored or sanctioned by an international, national or State organization, including, but not limited to, the American Motorcycle Association, or sponsored and/or sanctioned by an affiliate organization of an international, national or State organization that sanctions competitions, including trials or practices leading up to or in connection with a competition.

"Off-Highway Vehicle" or "OHV" means a motor-driven recreational vehicle capable of cross-country travel on natural terrain without benefit of a road or trail, including an all-terrain vehicle and off-highway motorcycle as defined in the

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Illinois Vehicle Code [625 ILCS 5/1-101.8 and 1-153.1]. "Off-Highway Vehicle" does not include a snowmobile, a motorcycle, a watercraft, snow-grooming equipment when used for its intended purpose, or an aircraft.

"Off-Highway Vehicle Usage Stamp" or "Off-Highway Vehicle Usage Sticker" means a stamp issued as a sticker by the Department allowing operation of an Off-Highway Vehicle in the State of Illinois.

**Section 2525.30 Application for Off-Highway Vehicle Usage Stamp**

- a) Individuals shall apply for an Off-Highway Vehicle Usage Stamp through an electronic application system. The application shall include the following information unless listed as optional:
  - 1) Name and address of purchaser.
  - 2) Date of birth of purchaser.
  - 3) Social Security Number or DNR Customer Number.
  - 4) Type of OHV:
    - A) ATV
    - B) UTV
    - C) Off-Highway Motorcycle
    - D) Golf Cart
    - E) Other Off-Highway Vehicle.
- b) The Department may designate vendors to sell Off-Highway Vehicle Usage Stamps in accordance with 17 Ill. Adm. Code 2520.
- c) *The fee for the Off-Highway Vehicle Usage Stamp shall be \$15 annually [20 ILCS 862/26].*

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- d) Off-Highway Vehicle Usage Stamps shall bear the calendar year the stamp is in effect and shall expire March 31 of each calendar year.
- e) If an Off-Highway Vehicle Usage Stamp is lost, destroyed, stolen or mutilated beyond legibility, a new Off-Highway Vehicle Usage Stamp shall be required before operating an OHV in any area that requires an Off-Highway Vehicle Usage Stamp. A valid Off-Highway Vehicle Usage Stamp already displayed on an OHV that is sold or transferred shall remain valid until the stamp is expired.

**Section 2525.40 Display of Off-Highway Vehicle Usage Stamp**

The owner of the OHV shall display the Off-Highway Vehicle Usage Stamp on the forward half of the OHV.

**Section 2525.50 Exception from Display of Off-Highway Vehicle Usage Stamp**

The operator of an off-highway vehicle shall not be required to display an Off-Highway Vehicle Usage Stamp if the off-highway vehicle is:

- a) Owned and used by the U.S. government, the State of Illinois, a political subdivision of Illinois, or another state, if the off-highway vehicle prominently displays the name of the owner.
- b) Operated on lands where the owner permanently resides; this exception shall not apply to clubs, associations, lands leased for hunting or recreational purposes, or off-highway vehicles being used by outfitters, as defined in 17 Ill. Adm. Code 640.10, as part of their outfitting business.
- c) Used only on international or national competition circuits in events for which written permission has been obtained by the sponsoring or sanctioning body from the governmental unit having jurisdiction over the location of any event held in this State.
- d) While being used for activities associated with farming or livestock production operations.
- e) While being used on an off-highway vehicle grant-assisted site if the off-highway vehicle displays an Off-Highway Vehicle Access decal.

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## NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Access to Information
- 2) Code Citation: 2 Ill. Adm. Code 1651
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
1651.110	Repeal
1651.120	Repeal
1651.210	Repeal
1651.220	Repeal
1651.310	Repeal
1651.320	Repeal
1651.410	Repeal
1651.420	Repeal
1651.510	Repeal
1651.520	Repeal
1651.530	Repeal
1651.APPENDIX A	Repeal
1651.APPENDIX B	Repeal
- 4) Statutory Authority: Implementing and authorized by Section 3(h) of the Freedom of Information Act [5 ILCS 140/3(h)] and implementing Section 5-15 of the Illinois Administrative Procedures Act [5 ILCS 100/5-15]
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A statement that a copy of the adopted rulemaking, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notices of Proposed published in the *Illinois Register*: This rulemaking is adopted pursuant to Section 5-15 of the Illinois Administrative Procedures Act (IAPA) [5 ILCS 100/5-15], so the board was not required to publish the rulemaking as a proposed rulemaking under Section 5-40 of the IAPA.
- 10) Has JCAR issued a Statement of Objection to this rulemaking: No

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- 11) Difference between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? N/A
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any rulemakings pending on this Part? No
- 15) Summary and Purpose of Repealer: The agency is repealing the current Access to Information rules and adopting the model FOIA rules to reflect changes made to the Freedom of Information Act [5 ILCS 140] by PA 96-542, which took effect on January 1, 2010.
- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Thomas Klein  
Capital Development Board  
401 South Spring Street  
3<sup>rd</sup> Floor Stratton Building  
Springfield, Illinois 62706

217/782-0700 office  
217/524-0565 fax

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- 1) Heading of the Part: Access to Records of the Capital Development Board
- 2) Code Citation: 2 Ill. Adm. Code 1651
- 3) 

<u>Section Number:</u>	<u>Adopted Action:</u>
1651.101	New Section
1651.102	New Section
1651.201	New Section
1651.202	New Section
1651.203	New Section
1651.301	New Section
1651.302	New Section
1651.303	New Section
1651.401	New Section
1651.402	New Section
1651.403	New Section
1651.404	New Section
1651.405	New Section
1651.406	New Section
1651.407	New Section
1651.501	New Section
1651.502	New Section
1651.503	New Section
1651.APPENDIX A	New Section
- 4) Statutory Authority: Implementing and authorized by Section 3(h) of the Freedom of Information Act [5 ILCS 140] and implementing Section 5-15 of the Illinois Administrative Procedures Act [5 ILCS 100/5-15]
- 5) Effective Date of Rules: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any material incorporated by reference, is on file in the Capital Development Board's principal office and is available for public inspection.

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- 9) Notice of Proposal Published in Illinois Register: This rulemaking is adopted pursuant to Section 5-15 of the Illinois Administrative Procedures Act (IAPA) [5 ILCS 100/5-15], so the Board was not required to publish this Part as a proposed rulemaking under Section 5-40 of the IAPA.
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between proposal and final version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? N/A
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any rulemaking pending on this Part? No.
- 15) Summary and Purpose of Rules: The Board is amending its Access to Public Records regulations to reflect changes made to the Freedom of Information Act [5 ILCS 140 by PA 96-542, which took effect on January 1, 2010.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Thomas Klein  
Capital Development Board  
401 South Spring Street  
3<sup>rd</sup> Floor Stratton Building  
Springfield, Illinois 62706

217/782-0700 office  
217/524-0565 fax

The full text of the Adopted Rules begins on the next page:

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NOTICE OF ADOPTED RULES

TITLE 2: GOVERNMENTAL ORGANIZATIONS  
SUBTITLE E: MISCELLANEOUS STATE AGENCIES  
CHAPTER VI: CAPITAL DEVELOPMENT BOARD

PART 1651  
ACCESS TO RECORDS OF THE CAPITAL DEVELOPMENT BOARD

SUBPART A: INTRODUCTION

Section	
1651.101	Summary and Purpose
1651.102	Definitions

SUBPART B: CLASSIFICATION OF RECORDS

Section	
1651.201	Records that Will Be Disclosed
1651.202	Records that Will Be Withheld from Disclosure
1651.203	Statutory Exemptions

SUBPART C: PROCEDURES FOR REQUESTING RECORDS FROM THE  
AGENCY

Section	
1651.301	Submittal of Requests for Records
1651.302	Information To Be Provided in Requests for Records
1651.303	Requests for Records for Commercial Purposes

SUBPART D: AGENCY RESPONSE TO REQUESTS FOR RECORDS

Section	
1651.401	Timeline for Agency Response
1651.402	Requests for Records that the Agency Considers Unduly Burdensome
1651.403	Requests for Records that Require Electronic Retrieval
1651.404	Denials of Requests for Records
1651.405	Requests for Review of Denials – Public Access Counselor
1651.406	Circuit Court Review
1651.407	Administrative Review

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## SUBPART E: PROCEDURES FOR PROVIDING RECORDS TO REQUESTERS

## Section

1651.501	Inspection of Records
1651.502	Copying of Records; Fees
1651.503	Reduction and Waiver of Fees

## 1651.APPENDIX A: Fee Schedule for Duplication and Certification of Records

AUTHORITY: Implementing and authorized by Section 3(h) of the Freedom of Information Act [5 ILCS 140] and implementing Section 5-15 of the Illinois Administrative Procedures Act [5 ILCS 100].

SOURCE: Adopted at 37 Ill. Reg. 9911, effective June 27, 2013.

## SUBPART A: INTRODUCTION

**Section 1651.101 Summary and Purpose**

- a) This part is established to implement the provisions of the Freedom of Information Act [5 ILCS 140]. The purpose of these rules is to support the policy of providing accessibility and transparency in obtaining public records retained by the Capital Development Board while protecting legitimate privacy interests and maintaining administrative efficiency.
- b) These rules establish the procedures by which the public may request and receive public records of the Capital Development Board. The rules also set forth the procedures that the Capital Development Board must comply with in responding to requests for information.

**Section 1651.102 Definitions**

Terms not defined in this Section will have the same meaning as in the Freedom of Information Act [5 ILCS 140]. The following definitions are applicable for purposes of this Part:

"Act" means Capital Development Board Act. [20 ILCS 3105]

"Agency" means Capital Development Board as established by the Act.

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"Commercial purpose" means the use of any part of a record or records, or information derived from records, in any form for sale, resale, or solicitation or advertisement for sales or services. For purposes of this definition, requests made by news media and non-profit, scientific, or academic organizations will not be considered to be made for a "commercial purpose" when the principal purpose of the request is:

to access and disseminate information concerning news and current or passing events;

for articles or opinion or features of interest to the public; or

for the purpose of academic, scientific, or public research or education.  
(Section 2(c-10) of FOIA)

"Copying" means the reproduction of any record by means of any photographic, electronic, mechanical, or other process, device or means now known or hereafter developed and available to the Agency. (Section 2(d) of FOIA.)

"Director" means the Director of the Agency.

"FOIA" means the Freedom of Information Act [5 ILCS 140].

"Freedom of Information Officer" or "FOI Officer" means an individual or individuals responsible for receiving and responding to request for public records.

"News media" means a newspaper or other periodical issued at regular intervals, news service in paper or electronic form, radio station, television station, television network, community antenna television service, or person or corporation engaged in making news reels or other motion picture news for public showing. (Section 2(f) of FOIA)

"Person" means any individual, corporation, partnership, firm, organization or association, acting individually or as a group. (Section 2(b) of FOIA)

"Private information" means unique identifiers, including a person's Social Security number, driver's license number, employee identification number, biometric identifiers, personal financial information, passwords or other access codes, medical records, home or personal telephone numbers, and personal email

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addresses. Private information also includes home address and personal license plates, except as otherwise provided by law or when compiled without possibility of attribution to any person. (Section 2(c-5) of FOIA)

"Public Body" means all legislative, executive, administrative, or advisory bodies of the State, State universities and colleges, counties, townships, cities, villages, incorporated towns, school districts and all other municipal corporations, boards, bureaus, committees or commissions of this State, and subsidiary bodies of any of the foregoing, including but not limited to committees and subcommittees thereof, and a School Finance Authority created under Article 1E of the School Code [105 ILCS 5]. (Section 2(a) of FOIA)

"Public Access Counselor" means an individual appointed to that office by the Attorney General under Section 7 of the Attorney General Act [15 ILCS 205].

"Records" means all records, reports, forms, writings, letters, memoranda, books, papers, maps, photographs, microfilms, cards, tapes, recordings, electronic data processing records, electronic communications, recorded information and all other documentary materials pertaining to the transaction of public business, regardless of physical form or characteristics, having been prepared by or for, or having been or being used by, received by, in the possession of or under the control of the Agency. (Section 2(c) of FOIA)

"Requester" is any person who has submitted to the Agency a written request, electronically or on paper, for records.

"Unwarranted invasion of personal privacy" means the disclosure of information that is highly personal or objectionable to a reasonable person and in which the subject's right to privacy outweighs any legitimate public interest in obtaining the information. (Section 7(1)(c) of FOIA)

## SUBPART B: CLASSIFICATION OF RECORDS

**Section 1651.201 Records that Will Be Disclosed**

Upon request meeting the requirements of this Part, the Agency will disclose to the requester all records requested except that it will not disclose certain records as provided in Section 1651.202 or 1651.203. Records covered under this Section will include, but are not be limited to:

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- a) Records of funds. All records relating to the obligation, receipt and use of public funds of the Agency are records subject to inspection and copying by the public. (Section 2.5 of FOIA)
- b) Payrolls. Certified payroll records submitted to the Agency under Section 5(a)(2) of the Prevailing Wage Act [820 ILCS 130] are records subject to inspection and copying in accordance with the provisions of FOIA; except that contractors' and employees' addresses, telephone numbers, and Social Security numbers will be redacted by the Agency prior to disclosure. (Section 2.10 of FOIA)
- c) Criminal history records. The following documents maintained by the Agency pertaining to criminal history record information are records subject to inspection and copying by the public pursuant to FOIA:
  - 1) Court records that are public;
  - 2) Records that are otherwise available under State or local law; and
  - 3) Records in which the requesting party is the individual identified, except as provided under Section 1651.202(a)(5)(F) of this Part. (Section 2.15(b) of FOIA)
- d) Settlement agreements. All settlement agreements entered into by or on behalf of the Agency are records subject to inspection and copying by the public, provided that information exempt from disclosure under Section 1651.202 or 1651.203 of this Part will be redacted. (Section 2.20 of FOIA)

**Section 1651.202 Records that Will Be Withheld from Disclosure**

When a request is made to inspect or copy a record that contains information that is otherwise exempt from disclosure under this Section, but also contains information that is not exempt from disclosure, the Agency will make the remaining information available for inspection and copying. (Section 7(1) of FOIA)

- a) Subject to this requirement and Section 7 of FOIA, the following will be exempt from inspection and copying:

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- 1) Information specifically prohibited from disclosure by federal or State law or rules and regulations implementing federal or State law; (Section 7(1)(a) of FOIA)
- 2) Private information, unless disclosure is required by another provision of FOIA, a State or federal law or a court order; (Section 7(1)(b) of FOIA)
- 3) Files, documents, and other data or databases maintained by one or more law enforcement agencies and specifically designed to provide information to one or more law enforcement agencies regarding the physical or mental status of one or more individual subjects; (Section 7(1)(b-5) of FOIA)
- 4) Personal information contained within records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, unless the disclosure is consented to in writing by the individual subjects of the information. "Unwarranted invasion of personal privacy" means the disclosure of information that is highly personal or objectionable to a reasonable person and in which the subject's right to privacy outweighs any legitimate public interest in obtaining the information. The disclosure of information that bears on the public duties of public employees and officials will not be considered an invasion of personal privacy; (Section 7(1)(c) of FOIA)
- 5) Records in the possession of any public body created in the course of administrative enforcement proceedings, and any law enforcement or correctional agency for law enforcement purposes, but only to the extent that disclosure would:
  - A) Interfere with pending or actually and reasonably contemplated law enforcement proceedings conducted by any law enforcement or correctional agency that is the recipient of the request;
  - B) Interfere with active administrative enforcement proceedings conducted by the public body that is the recipient of the request;
  - C) Create a substantial likelihood that a person will be deprived of a fair trial or an impartial hearing;

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- D) Unavoidably disclose the identity of a confidential source, confidential information furnished only by the confidential source, or persons who file complaints with or provide information to administrative, investigative, law enforcement, or penal agencies; except that the Agency will provide traffic accident reports, the identities of witnesses to traffic accidents, and rescue reports, except when disclosure would interfere with an active criminal investigation;
  - E) Disclose unique or specialized investigative techniques other than those generally used and known, or disclose internal documents of correctional agencies related to detection, observation or investigation of incidents of crime or misconduct, and disclosure would result in demonstrable harm to the Agency;
  - F) Endanger the life or physical safety of law enforcement personnel or any other person; or
  - G) Obstruct an ongoing criminal investigation by the agency that is the recipient of the request; (Section 7(1)(d) of FOIA)
- 6) Records that relate to or affect the security of correctional institutions and detention facilities; (Section 7(1)(e) of FOIA)
  - 7) Preliminary drafts, notes, recommendations, memoranda and other records in which opinions are expressed, or policies or actions are formulated, except that a specific record or relevant portion of a record will not be exempt when the record is publicly cited and identified by the head of the Agency. The exemption provided in this subsection (a)(7) extends to all those records of officers and agencies of the General Assembly that pertain to the preparation of legislative documents; (Section 7(1)(f) of FOIA)
  - 8) Trade secrets and commercial or financial information obtained from a person or business where the trade secrets or commercial or financial information are furnished under a claim that they are proprietary, privileged or confidential, and that disclosure of the trade secrets or commercial or financial information would cause competitive harm to the person or business, and only insofar as the claim directly applies to the

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records requested. All trade secrets and commercial or financial information obtained by a public body, including a public pension fund, from a private equity fund or a privately held company within the investment portfolio of a private equity fund as a result of either investing or evaluating a potential investment of public funds in a private equity fund. The exemption contained in this subsection (a)(8) does not apply to the aggregate financial performance information of a private equity fund, nor to the identity of the fund's managers or general partners. The exemption contained in this subsection (a)(8) does not apply to the identity of a privately held company within the investment portfolio of a private equity fund, unless the disclosure of the identity of a privately held company may cause competitive harm. Nothing in this subsection (a)(8) will be construed to prevent a person or business from consenting to disclosure; (Section 7(1)(g) of FOIA)

- 9) Proposals and bids for any contract, grant, or agreement, including information that if it were disclosed would frustrate procurement or give an advantage to any person proposing to enter into a contractor agreement with the body, until an award or final selection is made. Information prepared by or for the body in preparation of a bid solicitation will be exempt until an award or final selection is made; (Section 7(1)(h) of FOIA)
- 10) Valuable formulae, computer geographic systems, designs, drawings and research data obtained or produced by the Agency when disclosure could reasonably be expected to produce private gain or public loss. The exemption for "computer geographic systems" provided in this subsection (a)(10) does not extend to requests made by news media as defined in Section 1651.102 when the requested information is not otherwise exempt and the only purpose of the request is to access and disseminate information regarding the health, safety, welfare, or legal rights of the general public; (Section 7(1)(i) of FOIA)
- 11) The following information pertaining to educational matters:
  - A) Test questions, scoring keys, and other examination data used to administer an academic exam;

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- B) Information received by a primary or secondary school, college, or university under its procedure for the evaluation of faculty members by their academic peers;
  - C) Information concerning a school's or university's adjudication of student disciplinary cases, but only to the extent that disclosure would unavoidably reveal the identity of the student; and
  - D) Course materials or research materials used by faculty members. (Section 7(1)(j) of FOIA)
- 12) Architects' plans and engineers' technical submissions, and other construction related technical documents for projects not constructed or developed in whole or in part with public funds and for projects constructed or developed with public funds, including but not limited to power generating and distribution stations and other transmission and distribution facilities, water treatment facilities, airport facilities, sport stadiums, convention centers, and all government owned, operated, or occupied buildings, but only to the extent that disclosure would compromise security; (Section 7(1)(k) of FOIA)
- 13) Minutes of meetings of public bodies closed to the public as provided in the Open Meetings Act [5 ILCS 120] until the public body makes the minutes available to the public under Section 2.06 of the Open Meetings Act; (Section 7(1)(l) of FOIA)
- 14) Communications between the Agency and an attorney or auditor representing the Agency that would not be subject to discovery in litigation, and materials prepared or compiled by or for the Agency in anticipation of a criminal, civil or administrative proceeding upon the request of an attorney advising the Agency, and materials prepared or compiled with respect to internal audits of the Agency; (Section 7(1)(m) of FOIA)
- 15) Records relating to the Agency's adjudication of employee grievances or disciplinary cases; however, this exemption will not extend to the final outcome of cases in which discipline is imposed; (Section 7(1)(n) of FOIA)

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- 16) Administrative or technical information associated with automated data processing operations, including but not limited to software, operating protocols, computer program abstracts, file layouts, source listings, object modules, load modules, user guides, documentation pertaining to all logical and physical design of computerized systems, employee manuals, and any other information that, if disclosed, would jeopardize the security of the system or its data or the security of materials exempt under this Section; (Section 7(1)(o) of FOIA)
- 17) Records relating to collective negotiating matters between the Agency and its employees or representatives, except that any final contract or agreement will be subject to inspection and copying; (Section 7(1)(p) of FOIA)
- 18) Test questions, scoring keys, and other examination data used to determine the qualifications of an applicant for a license or employment; (Section 7(1)(q) of FOIA)
- 19) The records, documents and information relating to real estate purchase negotiations until those negotiations have been completed or otherwise terminated. With regard to a parcel involved in a pending or actually and reasonably contemplated eminent domain proceeding under the Eminent Domain Act [735 ILCS 30], records, documents and information relating to that parcel will be exempt except as may be allowed under discovery rules adopted by the Illinois Supreme Court. The records, documents and information relating to a real estate sale will be exempt only until a sale is consummated; (Section 7(1)(r) of FOIA)
- 20) Any and all proprietary information and records related to the operation of an intergovernmental risk management association or self-insurance pool or jointly self-administered health and accident cooperative or pool. Insurance or self-insurance (including any intergovernmental risk management association or self-insurance pool) claims, loss or risk management information, records, data, advice or communications; (Section 7(1)(s) of FOIA)
- 21) Information contained in or related to examination, operating, or condition reports prepared by, on behalf of, or for the use of a public body responsible for the regulation or supervision of financial institutions or

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insurance companies, unless disclosure is otherwise required by State law; (Section 7(1)(t) of FOIA)

- 22) Information that would disclose or might lead to the disclosure of secret or confidential information, codes, algorithms, programs or private keys intended to be used to create electronic or digital signatures under the Electronic Commerce Security Act [5 ILCS 175]; (Section 7(1)(u) of FOIA)
- 23) Vulnerability assessments, security measures, and response policies or plans that are designed to identify, prevent, or respond to potential attacks upon a community's population or systems, facilities, or installations, the destruction or contamination of which would constitute a clear and present danger to the health or safety of the community, but only to the extent that disclosure could reasonably be expected to jeopardize the effectiveness of the measures or the safety of the personnel who implement them or the public. Information exempt under this subsection (a)(23) may include such things as details pertaining to the mobilization or deployment of personnel or equipment, to the operation of communication systems or protocols, or to tactical operations; (Section 7(1)(v) of FOIA)
- 24) Maps and other records regarding the location or security of generation, transmission, distribution, storage, gathering, treatment, or switching facilities owned by a utility, by a power generator, or by the Illinois Power Agency; (Section 7(1)(x) of FOIA)
- 25) Information contained in or related to proposals, bids, or negotiations related to electric power procurement under Section 1-75 of the Illinois Power Agency Act [20 ILCS 3855] and Section 16-111.5 of the Public Utilities Act [220 ILCS 5] that is determined to be confidential and proprietary by the Illinois Power Agency or by the Illinois Commerce Commission; (Section 7(1)(y) of FOIA)
- 26) Information about students exempted from disclosure under Section 10-20.38 or 34-18.29 of the School Code, and information about undergraduate students enrolled at an institution of higher education exempted from disclosure under Section 25 of the Illinois Credit Card Marketing Act of 2009 [110 ILCS 26]; (Section 7(1)(z) of FOIA)

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- 27) Information the disclosure of which is exempted under the Viatical Settlements Act of 2009 [215 ILCS 158]; Section 7(1)(aa) of FOIA)
- 28) Information regarding interments, entombments, or inurnments of human remains that are submitted to the Cemetery Oversight Database under the Cemetery Care Act [760 ILCS 100] or the Cemetery Oversight Act [225 ILCS 411], whichever is applicable. (Section 7(1)(bb) of FOIA)
- b) A record that is not in the possession of the Agency but is in the possession of a party with whom the Agency has contracted to perform a governmental function on behalf of the Agency, and that directly relates to the governmental function and is not otherwise exempt under FOIA, will be considered a record of the Agency for purposes of Subpart C. (Section 7(2) of FOIA)

**Section 1651.203 Statutory Exemptions**

To the extent provided for by the following statutes, the following will be exempt from inspection and copying:

- a) All information determined to be confidential under Section 4002 of the Technology Advancement and Development Act [20 ILCS 700].
- b) Library circulation and order records identifying library users with specific materials under the Library Records Confidentiality Act [75 ILCS 70].
- c) Applications, related documents, and medical records received by the Experimental Organ Transplantation Procedures Board and any and all documents or other records prepared by the Experimental Organ Transplantation Procedures Board or its staff relating to applications it has received.
- d) Information and records held by the Department of Public Health and its authorized representatives relating to known or suspected cases of sexually transmissible disease or any information the disclosure of which is restricted under the Illinois Sexually Transmissible Disease Control Act [410 ILCS 325].
- e) Information the disclosure of which is exempted under Section 30 of the Radon Industry Licensing Act [420 ILCS 44].

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- f) Firm performance evaluations under Section 55 of the Architectural, Engineering, and Land Surveying Qualifications Based Selection Act [30 ILCS 535].
- g) Information the disclosure of which is restricted and exempted under Section 50 of the Illinois Prepaid Tuition Act [110 ILCS 979].
- h) Information the disclosure of which is exempted under the State Officials and Employees Ethics Act [5 ILCS 430] and records of any lawfully created State or Local inspector general's office that would be exempt if created or obtained by an Executive Inspector General's office under that Act.
- i) Information contained in a local emergency energy plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code [65 ILCS 5].
- j) Information and data concerning the distribution of surcharge moneys collected and remitted by wireless carriers under the Wireless Emergency Telephone Safety Act [20 ILCS 2605].
- k) Law enforcement officer identification information or driver identification information compiled by a law enforcement agency or the Department of Transportation under Section 11-212 of the Illinois Vehicle Code [65 ILCS 5].
- l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act [210 ILCS 28].
- m) Information provided to the predatory lending database created pursuant to Article 3 of the Residential Real Property Disclosure Act [765 ILCS 77], except to the extent authorized under that Article.
- n) Defense budgets and petitions for certification of compensation and expenses for court appointed trial counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act [725 ILCS 124]. This subsection (n) will apply until the conclusion of the trial of the case, even if the prosecution chooses not to pursue the death penalty prior to trial or sentencing.
- o) Information that is prohibited from being disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act [410 ILCS 525].

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- p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected or prepared by or for the Regional Transportation Authority Act [70 ILCS 3615] or the St. Clair County Transit District under the Bi-State Transit Safety Act [45 ILCS 111].
- q) Information prohibited from being disclosed by the Personnel Records Review Act [820 ILCS 40].
- r) Information prohibited from being disclosed by the Illinois School Student Records Act [105 ILCS 10].
- s) Information the disclosure of which is restricted under Section 5-108 of the Public Utilities Act [220 ILCS 5].

## SUBPART C: PROCEDURES FOR REQUESTING RECORDS FROM THE AGENCY

**Section 1651.301 Submittal of Requests for Records**

- a) Any request for public records should be submitted in writing to the FOI officer at the Agency. The FOI officer is located at 401 South Spring Street, 3<sup>rd</sup> Floor Wm. G. Stratton Building, Springfield, Illinois 62706.
- b) Contact information for the Agency FOI officer can be found online at [www.cdb.state.il.us](http://www.cdb.state.il.us).
- c) FOIA requests may be submitted via mail, e-mail, fax, or hand delivery. Requests should be mailed or hand delivered to:

Capital Development Board  
401 South Spring Street  
3<sup>rd</sup> Floor Wm. G. Stratton Building  
Springfield, IL 62706  
Attn.: FOI Officer

- d) E-mailed requests should be sent to [CDB.FOIA@Illinois.gov](mailto:CDB.FOIA@Illinois.gov), contain the request in the body of the e-mail, and indicate in the subject line of the e-mail that it contains a FOIA request. Faxed FOIA requests should be faxed to (217) 524-0565, Attn: FOI Officer.

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**Section 1651.302 Information To Be Provided in Requests for Records**

A request for records should include:

- a) The complete name, mailing address and telephone number of the requester;
- b) As specific a description as possible of the records sought. Requests that the Agency considers unduly burdensome or categorical may be denied; (See Section 3(g) of FOIA and Section 1651.402 of this Part)
- c) A statement as to the requested medium and format for the Agency to use in providing the records sought: for example paper, specific types of digital or magnetic media, or videotape;
- d) A statement as to the requested manner for the Agency to use in providing the records sought: for example, inspection at Agency headquarters or providing paper or electronic copies;
- e) A statement as to whether the requester needs certified copies of all or any portion of the records, including reference to the specific documents that require certification; and
- f) A statement as to whether the request is for a commercial purpose.

**Section 1651.303 Requests for Records for Commercial Purposes**

- a) It is a violation of FOIA for a person to knowingly obtain a record for a commercial purpose without disclosing that it is for a commercial purpose if requested to do so by the Agency.
- b) The Agency will respond to a request for records to be used for a commercial purpose within 21 working days after receipt. The response will:
  - 1) Provide to the requester an estimate of the time required by the Agency to provide the records requested and an estimate of the fees to be charged, which the Agency may require the person to pay in full before copying the requested documents;

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- 2) Deny the request pursuant to one or more of the exemptions set out in Section 1651.202 or 1651.203;
  - 3) Notify the requester that the request is unduly burdensome and extend an opportunity to the requester to attempt to reduce the request to manageable proportions; or
  - 4) Provide the records requested. (Section 3.1(a) of FOIA)
- c) Unless the records are exempt from disclosure, the Agency will comply with a request within a reasonable period considering the size and complexity of the request, and giving priority to records requested for non-commercial purposes. (Section 3.1(b) of FOIA)

## SUBPART D: AGENCY RESPONSE TO REQUESTS FOR RECORDS

**Section 1651.401 Timeline for Agency Response**

- a) Except as stated in subsection (b) or (c), the Agency will respond to any written request for records within 5 business days after its receipt of the request. Failure to comply with a written request, extend the time for response, or deny a request within 5 business days after its receipt will be considered a denial of the request. If the Agency fails to respond to a request within the requisite periods in this subsection (a) but thereafter provides the requester with copies of the requested records, it will not impose a fee for such copies. If the Agency fails to respond to a request received, it will not treat the request as unduly burdensome as provided under Section 1651.402. (Section 3 (d) of FOIA) A written request from the Agency to provide additional information will be considered a response to the FOIA request.
- b) The time limits prescribed in subsection (a) may be extended for not more than 5 business days from the original due date for any of the following reasons:
  - 1) The requested records are stored in whole or in part at locations other than the office having charge of the requested records;
  - 2) The request requires the collection of a substantial number of specified records;

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- 3) The request is couched in categorical terms and requires an extensive search for the records responsive to it;
  - 4) The requested records have not been located in the course of routine search and additional efforts are being made to locate them;
  - 5) The requested records require examination and evaluation by personnel having the necessary competence and discretion to determine if they are exempt from disclosure under Section 7 or 7.5 of FOIA or should be revealed only with appropriate deletions;
  - 6) The request for records cannot be complied with by the Agency within the time limits prescribed by subsection (a) without unduly burdening or interfering with the operations of the Agency; or
  - 7) There is a need for consultation, which will be conducted with all practicable speed, with another public body or among two or more components of a public body having a substantial interest in the determination or in the subject matter of the request. (Section 3(e) of FOIA)
- c) The person making a request and the Agency may agree in writing to extend the time for compliance for a period to be determined by the parties. If the requester and the Agency agree to extend the period for compliance, a failure by the Agency to comply with any previous deadlines will not be treated as a denial of the request for the records. (Section 3(e) of FOIA)
- d) When additional time is required for any of the reasons set forth in subsection (b), the Agency will, within 5 business days after receipt of the request, notify the person making the request of the reasons for the extension and the date by which the response will be forthcoming. Failure to respond within the time permitted for extension will be considered a denial of the request. If the Agency fails to respond to a request within the time permitted for extension but thereafter provides the requester with copies of the requested public records, it may not impose a fee for those copies. If the Agency issues an extension and subsequently fails to respond to the request, it will not treat the request as unduly burdensome under Section 1651.402. (Section 3(f) of FOIA)

**Section 1651.402 Requests for Records that the Agency Considers Unduly Burdensome**

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- a) The Agency will fulfill requests calling for all records falling within a category unless compliance with the request would unduly burden the Agency, there is no way to narrow the request, and the burden on the Agency outweighs the public interest in the information. Before invoking this exemption, the Agency will extend to the requester an opportunity to confer with it in an attempt to reduce the request to manageable proportions. (Section 3(g) of FOIA) The amended request must be in writing.
- b) If the Agency determines that a request is unduly burdensome, it will do so in writing, specifying the reasons why it would be unduly burdensome and the extent to which compliance will so burden the operations of the Agency. Such a response will be treated as a denial of the request for information. (Section 3(g) of FOIA)
- c) Repeated requests for records that are unchanged or identical to records previously provided or properly denied under this Part from the same person will be deemed unduly burdensome. (Section 3(g) of FOIA)

**Section 1651.403 Requests for Records that Require Electronic Retrieval**

- a) A request for records that requires electronic retrieval will be treated the same as any other request for records, with the same timeline and extensions as allowed for other records.
- b) The Agency will retrieve and provide electronic records only in a format and medium that is available to the Agency.

**Section 1651.404 Denials of Requests for Records**

- a) The Agency will deny requests for records when:
  - 1) Compliance with the request would unduly burden the Agency, as determined pursuant to Section 1651.402, and the requester has not reduced the request to manageable proportions; or
  - 2) The records are exempt from disclosure pursuant to Section 7 or 7.5 of FOIA or Section 1651.202 or 1651.203.

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- b) The denial of a request for records must be in writing.
  - 1) The notification will include a description of the records denied; the reason for the denial, including a detailed factual basis for the application of any exemption claimed; and the names and titles or positions of each person responsible for the denial; (Section 9(a) of FOIA)
  - 2) Each notice of denial will also inform such person of the right to review by the Public Access Counselor and provide the address and phone number for the Public Access Counselor (Section 9(a) of FOIA); and
  - 3) When a request for records is denied on the grounds that the records are exempt under Section 7 or Section 7.5 of FOIA, the notice of denial will specify the exemption claimed to authorize the denial and the specific reasons for the denial, including a detailed factual basis and a citation to the supporting legal authority. (Section 9(b) of FOIA)
- c) A requester may treat the Agency's failure to respond to a request for records within 5 business days after receipt of the written request as a denial for purposes of the right to review by the Public Access Counselor.
- d) If the Agency has given written notice pursuant to Section 1651.401(d), failure to respond to a written request within the time permitted for extension may be treated as a denial for purposes of the right to review by the Public Access Counselor.
- e) Any person making a request for records will be deemed to have exhausted his or her administrative remedies with respect to that request if the Agency fails to act within the time periods provided in Section 1651.401. (Section 9(c) of FOIA)

**Section 1651.405 Requests for Review of Denials – Public Access Counselor**

- a) A person whose request to inspect or copy a record is denied by the Agency may file a request for review with the Public Access Counselor established in the Office of the Attorney General not later than 60 days after the date of the final denial. (Section 9.5(a) of FOIA)
- b) If the Agency asserts that the records are exempt under Section 1651.202(a)(4) or (a)(7), it will, within the time periods provided for responding to a request,

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provide written notice to the requester and the Public Access Counselor of its intent to deny the request in whole or in part. The notice will include:

- 1) A copy of the request for access to records;
  - 2) The proposed response from the Agency; and
  - 3) A detailed summary of the Agency's basis for asserting the exemption. (Section 9.5(b) of FOIA)
- c) Upon receipt of a notice of intent to deny from the Agency, the Public Access Counselor will determine whether further inquiry is warranted. The Public Access Counselor will process the notification of intent to deny as detailed in Section 9.5(b) of FOIA. Times for response or compliance by the Agency under Section 1651.401 will be tolled until the Public Access Counselor concludes his or her inquiry. (Section 9.5(b) of FOIA)
- d) Within 7 working days after the Agency receives a request for review from the Public Access Counselor, the Agency will provide copies of records requested and will otherwise fully cooperate with the Public Access Counselor. (Section 9.5(c) of FOIA)
- e) Within 7 working days after it receives a copy of a request for review and request for production of records from the Public Access Counselor, the Agency may, but is not required to, answer the allegations of the request for review. The answer may take the form of a letter, brief, or memorandum. The Public Access Counselor will forward a copy of the answer to the person submitting the request for review, with any alleged confidential information to which the request pertains redacted from the copy. (Section 9.5(d) of FOIA)
- f) The requester may, but is not required to, respond in writing to the answer within 7 working days and will provide a copy of the response to the Agency. (Section 9.5(d) of FOIA)
- g) In addition to the request for review, and the answer and response thereto, if any, a requester or the Agency may furnish affidavits or records concerning any matter germane to the review. (Section 9.5(e) of FOIA)

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- h) A binding opinion from the Attorney General will be binding upon both the requester and the Agency, subject to administrative review under Section 1651.407. (Section 9.5(f) of FOIA)
- i) If the Attorney General decides to exercise his or her discretion to resolve a request for review by mediation or by a means other than issuance of a binding opinion, the decision not to issue a binding opinion will not be reviewable. (Section 9.5(f) of FOIA)
- j) Upon receipt of a binding opinion concluding that a violation of FOIA has occurred, the Agency will either take necessary action immediately to comply with the directive of the opinion or will initiate administrative review under Section 1651.407. If the opinion concludes that no violation of FOIA has occurred, the requester may initiate administrative review under Section 1651.407. (Section 9.5(f) of FOIA)
- k) If the Agency discloses records in accordance with an opinion of the Attorney General, the Agency is immune from all liabilities by reason thereof and will not be liable for penalties under FOIA. (Section 9.5(f) of FOIA)
- l) If the requester files suit under Section 1651.406 with respect to the same denial that is the subject of a pending request for review, the requester will notify the Public Access Counselor, and the Public Access Counselor will so notify the Agency. (Section 9.5(g) of FOIA)
- m) The Attorney General may also issue advisory opinions to the Agency regarding compliance with FOIA. A review may be initiated upon receipt of a written request from the Director of the Agency or the Agency's Chief Legal Counsel, which will contain sufficient accurate facts from which a determination can be made. The Public Access Counselor may request additional information from the Agency in order to assist in the review. If the Agency relies in good faith on an advisory opinion of the Attorney General in responding to a request, the Agency is not liable for penalties under FOIA, so long as the facts upon which the opinion is based have been fully and fairly disclosed to the Public Access Counselor. (Section 9.5(h) of FOIA)

**Section 1651.406 Circuit Court Review**

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A requester also has the right to file suit for injunctive or declaratory relief in the Circuit Court for Sangamon County or for the county in which the requester resides, in accordance with the procedures set forth in Section 11 of FOIA.

**Section 1651.407 Administrative Review**

A binding opinion issued by the Attorney General will be considered a final decision of an administrative agency, for purposes of administrative review under the Administrative Review Law [735 ILCS 5/Art. III]. An action for administrative review of a binding opinion of the Attorney General will be commenced in Cook County or Sangamon County. An advisory opinion issued to the Agency will not be considered a final decision of the Attorney General for purposes of this Section. (Section 11.5 of FOIA)

## SUBPART E: PROCEDURES FOR PROVIDING RECORDS TO REQUESTERS

**Section 1651.501 Inspection of Records**

- a) The Agency may make available records for personal inspection at the Agency's headquarters office located at 401 S. Spring St., 3<sup>rd</sup> Floor, William G. Stratton Building, Springfield, IL 62706, or at another location agreed to by both the Agency and the requester. No original record will be removed from State-controlled premises except under constant supervision of the agency responsible for maintaining the record. The Agency may provide records in duplicate forms, including, but not limited to, paper copies, data processing printouts, videotape, microfilm, audio tape, reel to reel microfilm, photographs, computer disks and diazo.
- b) When a person requests a copy of a record maintained in an electronic format, the Agency will furnish it in the electronic format specified by the requester, if feasible. If it is not feasible to furnish the records in the specified electronic format, then the Agency will furnish it in the format in which it is maintained by the Agency, or in paper format at the option of the requester. (Section 6(a) of FOIA)
- c) A requester may inspect records by appointment only, scheduled subject to space availability. The Agency will schedule inspection appointments to take place during normal business hours, which are 8:30 a.m. to 5:00 p.m. Monday through Friday, exclusive of State holidays. If the requester must cancel the viewing

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appointment, the requester will so inform the Agency as soon as possible before the appointment.

- d) In order to maintain routine Agency operations, the requester may be asked to leave the inspection area for a specified period of time.
- e) The requester will have access only to the designated inspection area.
- f) Requesters will not be permitted to take briefcases, folders or similar materials into the room where the inspection takes place. An Agency employee may be present during the inspection.
- g) The requester will segregate and identify the documents to be copied during the course of the inspection.

**Section 1651.502 Copying of Records; Fees**

- a) In accordance with Section 1651.503, unless a fee is otherwise fixed by statute, the Agency will provide copies of records and certifications of records in accordance with the fee schedule set forth in Appendix A.
- b) In calculating its actual cost for reproducing records or for the use of the equipment of the Agency to reproduce records, the Agency will not include the costs of any search for and review of the records or other personnel costs associated with reproducing the records. (Section 6(b) of FOIA)
- c) In order to expedite the copying of records that the Agency cannot copy, due to the volume of the request or the operational needs of the Agency, in the timelines established in Section 1651.401, the requester may provide, at the requester's expense, the copy machine, all necessary materials, and the labor to copy the public records at the Agency headquarters in Section 1651.501(a), or at another location agreed to by both the Agency and the requester. No original record will be removed from State-controlled premises except under constant supervision of the agency responsible for maintaining the record.
- d) Copies of records will be provided to the requester only upon payment of any fees due. The Agency may charge the requester for the actual cost of purchasing the recording medium, whether disc, diskette, tape, or other medium, but the Agency will not charge the requester for the costs of any search for and review of the

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records or other personnel costs associated with reproducing the records. (Section 6(a) of FOIA) Payment must be by check or money order sent to the Agency, payable to "Treasurer, State of Illinois."

- e) If a contractor is used to inspect or copy records, the following procedures will apply:
- 1) The requester, rather than the Agency, must contract with the contractor;
  - 2) The requester is responsible for all fees charged by the contractor;
  - 3) The requester must notify the Agency of the contractor to be used prior to the scheduled on-site inspection or copying;
  - 4) Only Agency personnel may provide records to the contractor;
  - 5) The Agency must have verification that the requester has paid the Agency, if payment is due, for the copying of the records before providing the records to the contractor; and
  - 6) The requester must provide to the Agency the contractor's written agreement to hold the records secure and to copy the records only for the purpose stated by the requester.

**Section 1651.503 Reduction and Waiver of Fees**

- a) Fees may be reduced or waived by the Agency if the requester states the specific purpose for the request and indicates that a waiver or reduction of the fee is in the public interest. In making this determination, the Agency will consider the following:
- 1) Whether the principal purpose of the request is to disseminate information regarding the health, safety, welfare, or legal rights of the general public; and
  - 2) Whether the principal purpose of the request is personal or commercial benefit. For purposes of this subsection (a), "commercial benefit" will not apply to requests made by news media when the principal purpose of the request is to access and disseminate information regarding the health,

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safety, welfare or legal rights of the general public. (Section 6(c) of FOIA)

- b) The Agency will provide copies of records without charge to federal, State, and municipal agencies, Constitutional officers and members of the General Assembly, and not-for-profit organizations providing evidence of good standing with the Secretary of State's Office.
- c) Except to the extent that the General Assembly expressly provides, statutory fees applicable to copies of records when furnished in a paper format will not be applicable to those records when furnished to a requester in an electronic format. (Section 6(a) of FOIA)

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**Section 1651.APPENDIX A Fee Schedule for Duplication and Certification of Records**

TYPE OF DUPLICATION	FEE (PER COPY)
Paper copy from original, up to and including 50 copies of black and white, letter or legal sized copies	No charge
Paper copy from original, in excess of 50 copies of black and white, letter or legal sized copies	\$.15/page
Paper copy from microfilm original	\$.15/page
Microfilm diazo from original	\$.50/diazo
VHS video copy of tape	Actual cost of the reproduction
Audio tape copy of tape	Actual cost of the reproduction
CD ROM disk	Actual cost of the reproduction
Photograph from negative	Actual cost of the reproduction
Blueprints/oversized prints	Actual cost of the reproduction
Paper copies in color or in a size other than letter or legal	Actual cost of the reproduction
Certification fee	\$1.00/record

NOTE: Expense for delivery other than by First Class U.S. Mail must be borne by the requester.

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- 1) Heading of the Part: Pay Plan
- 2) Code Citation: 80 Ill. Adm. Code 310
- 3)
 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
310.45	Amendment
310.47	Amendment
310.50	Amendment
310.130	Amendment
310.220	Amendment
310.410	Amendment
310.500	Amendment
310.APPENDIX A TABLE A	Amendment
310.APPENDIX A TABLE G	Amendment
310.APPENDIX A TABLE J	Amendment
310.APPENDIX A TABLE S	Amendment
310.APPENDIX A TABLE W	Amendment
310.APPENDIX A TABLE AD	Amendment
310.APPENDIX B TABLE J	Amendment
310.APPENDIX B TABLE S	Amendment
310.APPENDIX B TABLE W	Amendment
310.APPENDIX B TABLE AD	Amendment
310.APPENDIX C	New
310.APPENDIX C ILLUSTRATION A	New
310.APPENDIX C ILLUSTRATION B	New
310.APPENDIX C ILLUSTRATION C	New
- 4) Statutory Authority: Authorized by Sections 8, 8a and 9(7) of the Personnel Code [20 ILCS 415/8, 20 ILCS 415/8a and 20 ILCS 415/9(7)].
- 5) Effective Date of Amendments: July 1, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A statement that a copy of the adopted amendment including any material incorporated by reference is on file in the Agency's principal office and is available for public inspection.

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- 9) Notices of Proposed published in the *Illinois Register*: 37 Ill. Reg. 3462; March 29, 2013.
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: Since the First Notice, the changes are based on two intervening rulemakings, one published rulemaking, CMS corrections and JCAR staff recommendations. They are:

In the table of contents, changes are to Section labels that were changed in intervening rulemakings.

In the main source notes, the changes are to remove the word "on" in three locations and to include the page number and effective date of two intervening rulemakings and one published rulemaking since the First Notice was filed.

In Section 310.45, references to the new Illustrations and the tense of a verb are corrected.

In Section 310.50, the Board reference and citation in "bargaining unit" definition are corrected.

In Sections 310.410, 310.500, 310.Appendix A Tables C and W and 310.Appendix B Tables C and W, the changes are based on changes in an intervening rulemaking.

In Section 310.Appendix A Table A, the changes are to center a table label so that it is consistent with other table labels.

In Section 310.Appendix A Table S, two incomplete rate tables are stricken as a correction and to eliminate duplication.

In Section 310.Appendix B Table S, two Pay Plan Codes for pay grade 23 are corrected.

In Sections 310.Appendix C Illustrations A, B and C, the label for Appendix C is corrected to match that in the table of contents and the sections' source notes are corrected to include the prior repealing of Appendix C.

Since the First Notice Changes, the Sections 310.Appendices A and B Table C were

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removed from the amendments based on the changes proposed being adopted in intervening rulemaking and Second Notice Changes. The Main Source Notes, Sections 310.Appendix A Tables J, W and AD include the peremptory amendments effective June 19, 2013.

- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any other proposed rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: In the table of contents, 310.Appendix C is added with its Illustrations A, B and C.

Section 310.45 contains the initial actions needed to ultimately determine an employee's movement as defined in other sections and whether the employee's movement warrants a change to the employee's salary. The initial actions in Section 310.45 may result in comparing two rates of pay. The changes to Section 310.45 clarify when and how to determine exactly which two rates of pay to compare given specific information regarding the two classifications. Section 310.45 changes coincide with the addition of Sections 310.Appendix C Illustrations A, B and C.

In Section 310.47, the closed Zeller facility is removed from the Physician Specialist Options C and D titles' in-hiring rates.

In Section 310.50, the following definitions are added: bargaining representative; bargaining unit; classification; class specification; divided class; and whole class.

In Section 310.130, the fiscal year is changed to 2014.

In Section 310.220, a grammatical error is corrected, the merit compensation system out-of-state rates are referenced, and the frozen rates are referenced.

In Section 310.410, MS- salary ranges are assigned to the Blasting Expert, Blasting Specialist, Blasting Supervisor, Cancer Registrar I, II and III, Cancer Registrar Assistant Manager, Cancer Registrar Manager, Photographer and Sex Offender Therapist I and II titles. The Blasting Expert, Blasting Specialist, Blasting Supervisor titles were approved to be established by the Civil Service Commission effective December 1, 2012. The

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other titles were recently assigned bargaining unit pay grades in peremptory amendments. The Conservation Police Lieutenant title's title code is corrected. The Photographer I, II and III titles are removed as abolishing the titles was approved effective December 1, 2012 by the Civil Service Commission.

In Section 310.500, the classification and class specification definitions are added.

In Section 310.Appendix A Table A, the Conservation Police Lieutenant title's title code is corrected.

In Section 310.Appendix A Table C, the heading is made identical to that in the table of contents.

In Section 310.Appendix A Table G, bargaining unit RC-045 rates are corrected. The corrected rates have not been agreed to by the bargaining unit to date. The corrected rates are based on language in the Resolution Prior to Arbitration signed August 18, 2010. No signed RC-045 revised rate Memorandum of Understanding (MOU) exists.

In Section 310.Appendix A Table J, the Photographer I, II and III are removed from the title table. Please see the reference to the Civil Service Commission action in the above paragraph on Section 310.410.

In Section 310.Appendix A Table S, the bargaining unit VR-704 rates are corrected. The corrected rates have not been agreed to by the bargaining unit to date. The corrected rates are based on language in the MOU signed August 26, 2010. The MOU language varies from the VR-704-23 pay grade rates in the VR-704-23 Revised Rates MOU signed September 15, 2010.

In Section 310.Appendix A Table W and the title table, the Cancer Registrar I and III, Cancer Registrar Assistant Manager, Cancer Registrar Manager and Sex Offender Therapist I and II titles and their pay assignments are added. The titles' MOUs were signed November 26, 2012, too long ago for peremptory amendments to be filed. The pay grade assignment for the Social Worker I title is corrected.

In Section 310.Appendix A Table AD, the Blasting Expert, Blasting Specialist and Blasting Supervisor titles and their pay assignments are added in a title table. The title table with the Public Service Administrator title option 8X with the blasting expert, blasting specialist and blasting supervisor functions is removed. The note is removed. Please see the reference to the titles in the above paragraph on Section 310.410.

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In Section 310.Appendix B Table C, the heading is made to match that in the table of contents.

In Section 310.Appendix B Table J, the Photographer title is added to and the Photographer I, II and III titles are removed from the title table. Please see the reference to the Civil Service Commission action in the above paragraph on Section 310.410. By adding the Photographer title, the title table matches that in 310.Appendix A Table S.

In Section 310.Appendix B Table S, the Public Service Administrator title Option 8L positions at the Department of State Police, Senior Public Service Administrator title Option 7 positions at the Department of State Police with several specific functions and the newly hired into the Shift Supervisor title are added to the title table. By these changes, the title table matches that in 310.Appendix A Table S. The Note is changed to include a reference for the Senior Public Service Administrator title Option 7. Frozen rates associated with the newly hired into the Shift Supervisor title and the Senior Public Service Administrator title Option 7 positions with the deputy laboratory director function at Department of State Police are added.

In Section 310.Appendix B Table W, the Cancer Registrar I and III, Cancer Registrar Assistant Manager, Cancer Registrar Manager, Public Service Administrator Options 9A and 9B, Senior Public Service Administrator Option 7 at the Gaming Board and Department of Revenue and Sex Offender Therapist I and II titles and their pay assignments are added to the title table to match the title table in 310.Appendix A Table W. Pay grade RC-062-26 Pay Plan Code Q rates are added to the rate table.

In Section 310.Appendix B Table AD, the Blasting Expert, Blasting Specialist and Blasting Supervisor titles and their pay assignments are added in a title table. The title table with the Public Service Administrator title option 8X with the blasting expert, blasting specialist and blasting supervisor functions is removed. The note is removed. Please see reference to the titles in the above paragraph regarding Section 310.410.

The Sections 310.Appendix C Illustrations A, B and C are added and flowcharts indicating exactly which two rates of pay as referred to in changes found in Section 310.45.

- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Mr. Jason Doggett

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Manager  
Compensation Section  
Division of Technical Services and Agency Training and Development  
Bureau of Personnel  
Department of Central Management Services  
504 William G. Stratton Building  
Springfield IL 62706

Telephone: 217/782-7964  
Fax: 217/524-4570  
CMS.PayPlan@Illinois.gov

- 17) Does this rulemaking require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code [30 ILCS 50/5-25]? No

The full text of the Adopted Amendments begins on the next page:

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES  
SUBTITLE B: PERSONNEL RULES, PAY PLANS, AND  
POSITION CLASSIFICATIONS

## CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 310  
PAY PLAN

## SUBPART A: NARRATIVE

Section	
310.20	Policy and Responsibilities
310.30	Jurisdiction
310.40	Pay Schedules
310.45	Comparison of Pay Grades or Salary Ranges Assigned to Classifications
310.47	In-Hiring Rate
310.50	Definitions
310.60	Conversion of Base Salary to Pay Period Units
310.70	Conversion of Base Salary to Daily or Hourly Equivalents
310.80	Increases in Pay
310.90	Decreases in Pay
310.100	Other Pay Provisions
310.110	Implementation of Pay Plan Changes (Repealed)
310.120	Interpretation and Application of Pay Plan
310.130	Effective Date
310.140	Reinstitution of Within Grade Salary Increases (Repealed)
310.150	Fiscal Year 1985 Pay Changes in Schedule of Salary Grades, effective July 1, 1984 (Repealed)

## SUBPART B: SCHEDULE OF RATES

Section	
310.205	Introduction
310.210	Prevailing Rate
310.220	Negotiated Rate
310.230	Part-Time Daily or Hourly Special Services Rate (Repealed)
310.240	Daily or Hourly Rate Conversion
310.250	Member, Patient and Inmate Rate
310.260	Trainee Rate

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310.270	Legislated Rate
310.280	Designated Rate
310.290	Out-of-State Rate (Repealed)
310.295	Foreign Service Rate (Repealed)
310.300	Educator Schedule for RC-063 and HR-010
310.310	Physician Specialist Rate
310.320	Annual Compensation Ranges for Executive Director and Assistant Executive Director, State Board of Elections (Repealed)
310.330	Excluded Classes Rate (Repealed)

## SUBPART C: MERIT COMPENSATION SYSTEM

Section	
310.410	Jurisdiction
310.415	Merit Compensation Salary Range Assignments
310.420	Objectives
310.430	Responsibilities
310.440	Merit Compensation Salary Schedule
310.450	Procedures for Determining Annual Merit Increases and Bonuses
310.455	Intermittent Merit Increase (Repealed)
310.456	Merit Zone (Repealed)
310.460	Other Pay Increases
310.470	Adjustment
310.480	Decreases in Pay
310.490	Other Pay Provisions
310.495	Broad-Band Pay Range Classes
310.500	Definitions
310.510	Conversion of Base Salary to Pay Period Units (Repealed)
310.520	Conversion of Base Salary to Daily or Hourly Equivalents
310.530	Implementation
310.540	Annual Merit Increase and Bonus Guidechart
310.550	Fiscal Year 1985 Pay Changes in Merit Compensation System, effective July 1, 1984 (Repealed)

SUBPART D: FROZEN NEGOTIATED-RATES-OF-PAY DUE TO  
FISCAL YEAR APPROPRIATIONS AND EXPIRED SALARY SCHEDULES IN  
COLLECTIVE BARGAINING UNIT AGREEMENTS

Section

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310.600	Jurisdiction
310.610	Pay Schedules
310.620	In-Hiring Rate
310.630	Definitions
310.640	Increases in Pay
310.650	Other Pay Provisions
310.660	Effective Date
310.670	Negotiated Rate
310.680	Trainee Rate
310.690	Educator Schedule for Frozen RC-063 and Frozen HR-010
310.APPENDIX A	Negotiated Rates of Pay
310.TABLE A	RC-104 (Conservation Police Supervisors, Laborers' – ISEA Local #2002)
310.TABLE B	VR-706 (Assistant Automotive Shop Supervisors, Automotive Shop Supervisors and Meat and Poultry Inspector Supervisors, Laborers' – ISEA Local #2002)
310.TABLE C	RC-056 (Site Superintendents and Departments of Veterans' Affairs, Natural Resources, Human Services and Agriculture and Historic Preservation Agency Managers, IFPE)
310.TABLE D	HR-001 (Teamsters Local #700)
310.TABLE E	RC-020 (Teamsters Local #330)
310.TABLE F	RC-019 (Teamsters Local #25)
310.TABLE G	RC-045 (Automotive Mechanics, IFPE)
310.TABLE H	RC-006 (Corrections Employees, AFSCME)
310.TABLE I	RC-009 (Institutional Employees, AFSCME)
310.TABLE J	RC-014 (Clerical Employees, AFSCME)
310.TABLE K	RC-023 (Registered Nurses, INA)
310.TABLE L	RC-008 (Boilermakers)
310.TABLE M	RC-110 (Conservation Police Lodge)
310.TABLE N	RC-010 (Professional Legal Unit, AFSCME)
310.TABLE O	RC-028 (Paraprofessional Human Services Employees, AFSCME)
310.TABLE P	RC-029 (Paraprofessional Investigatory and Law Enforcement Employees, IFPE)
310.TABLE Q	RC-033 (Meat Inspectors, IFPE)
310.TABLE R	RC-042 (Residual Maintenance Workers, AFSCME)
310.TABLE S	VR-704 (Departments of Corrections, Financial and Professional Regulation, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002)

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310.TABLE T	HR-010 (Teachers of Deaf, IFT)
310.TABLE U	HR-010 (Teachers of Deaf, Extracurricular Paid Activities)
310.TABLE V	CU-500 (Corrections Meet and Confer Employees)
310.TABLE W	RC-062 (Technical Employees, AFSCME)
310.TABLE X	RC-063 (Professional Employees, AFSCME)
310.TABLE Y	RC-063 (Educators and Educator Trainees, AFSCME)
310.TABLE Z	RC-063 (Physicians, AFSCME)
310.TABLE AA	NR-916 (Departments of Central Management Services, Natural Resources and Transportation, Teamsters)
310.TABLE AB	RC-150 (Public Service Administrators Option 6, AFSCME) (Repealed)
310.TABLE AC	RC-036 (Public Service Administrators Option 8L Department of Healthcare and Family Services, INA)
310.TABLE AD	RC-184 (Public Service Administrators Option 8X Department of Natural Resources, SEIU Local 73)
310.TABLE AE	RC-090 (Internal Security Investigators, Metropolitan Alliance of Police Chapter 294)
310.APPENDIX B	Frozen Negotiated-Rates-of-Pay
310.TABLE A	Frozen RC-104-Rates-of-Pay (Conservation Police Supervisors, Laborers' – ISEA Local #2002)
310.TABLE C	Frozen RC-056-Rates-of-Pay (Site Superintendents and Departments of Veterans' Affairs, Natural Resources, Human Services and Agriculture and Historic Preservation Agency Managers, IFPE)
310.TABLE H	Frozen RC-006-Rates-of-Pay (Corrections Employees, AFSCME)
310.TABLE I	Frozen RC-009-Rates-of-Pay (Institutional Employees, AFSCME)
310.TABLE J	Frozen RC-014-Rates-of-Pay (Clerical Employees, AFSCME)
310.TABLE K	Frozen RC-023-Rates-of-Pay (Registered Nurses, INA)
310.TABLE M	Frozen RC-110-Rates-of-Pay (Conservation Police Lodge)
310.TABLE N	Frozen RC-010 (Professional Legal Unit, AFSCME)
310.TABLE O	Frozen RC-028-Rates-of-Pay (Paraprofessional Human Services Employees, AFSCME)
310.TABLE P	Frozen RC-029-Rates-of-Pay (Paraprofessional Investigatory and Law Enforcement Employees, IFPE)
310.TABLE R	Frozen RC-042-Rates-of-Pay (Residual Maintenance Workers, AFSCME)
310.TABLE S	Frozen VR-704-Rates-of-Pay (Departments of Corrections, Financial and Professional Regulation, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002)

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310.TABLE T	Frozen HR-010-Rates-of-Pay (Teachers of Deaf, IFT)
310.TABLE V	Frozen CU-500-Rates-of-Pay (Corrections Meet and Confer Employees)
310.TABLE W	Frozen RC-062-Rates-of-Pay (Technical Employees, AFSCME)
310.TABLE X	Frozen RC-063-Rates-of-Pay (Professional Employees, AFSCME)
310.TABLE Y	Frozen RC-063-Rates-of-Pay (Educators and Educator Trainees, AFSCME)
310.TABLE Z	Frozen RC-063-Rates-of-Pay (Physicians, AFSCME)
310.TABLE AB	Frozen RC-150-Rates-of-Pay (Public Service Administrators Option 6, AFSCME) (Repealed)
310.TABLE AD	Frozen RC-184-Rates-of-Pay (Public Service Administrators Option 8X Department of Natural Resources, SEIU Local 73)
310.TABLE AE	Frozen RC-090-Rates-of-Pay (Internal Security Investigators, Metropolitan Alliance of Police Chapter 294)
310.APPENDIX C	<u>Comparison of Pay Grades or Salary Ranges Assigned to Classifications</u> <del>Medical Administrator Rates (Repealed)</del>
<u>310.ILLUSTRATION A</u>	<u>Classification Comparison Flow Chart: Both Classes are Whole</u>
<u>310.ILLUSTRATION B</u>	<u>Classification Comparison Flow Chart: One Class is Whole and One is Divided</u>
<u>310.ILLUSTRATION C</u>	<u>Classification Comparison Flow Chart: Both Classes are Divided</u>
310.APPENDIX D	Merit Compensation System Salary Schedule
310.APPENDIX E	Teaching Salary Schedule (Repealed)
310.APPENDIX F	Physician and Physician Specialist Salary Schedule (Repealed)
310.APPENDIX G	Broad-Band Pay Range Classes Salary Schedule

AUTHORITY: Implementing and authorized by Sections 8 and 8a of the Personnel Code [20 ILCS 415/8 and 8a].

SOURCE: Filed June 28, 1967; codified at 8 Ill. Reg. 1558; emergency amendment at 8 Ill. Reg. 1990, effective January 31, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 2440, effective February 15, 1984; emergency amendment at 8 Ill. Reg. 3348, effective March 5, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 4249, effective March 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 5704, effective April 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 7290, effective May 11, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 11299, effective June 25, 1984; emergency amendment at 8 Ill. Reg. 12616, effective July 1, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 15007, effective August 6, 1984, for a maximum of 150

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days; amended at 8 Ill. Reg. 15367, effective August 13, 1984; emergency amendment at 8 Ill. Reg. 21310, effective October 10, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 21544, effective October 24, 1984; amended at 8 Ill. Reg. 22844, effective November 14, 1984; emergency amendment at 9 Ill. Reg. 1134, effective January 16, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 1320, effective January 23, 1985; amended at 9 Ill. Reg. 3681, effective March 12, 1985; emergency amendment at 9 Ill. Reg. 4163, effective March 15, 1985, for a maximum of 150 days; emergency amendment at 9 Ill. Reg. 9231, effective May 31, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 9420, effective June 7, 1985; amended at 9 Ill. Reg. 10663, effective July 1, 1985; emergency amendment at 9 Ill. Reg. 15043, effective September 24, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 3230, effective January 24, 1986; preemptory amendment at 10 Ill. Reg. 3325, effective January 22, 1986; emergency amendment at 10 Ill. Reg. 8904, effective May 13, 1986, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 8928, effective May 13, 1986; emergency amendment at 10 Ill. Reg. 12090, effective June 30, 1986, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 13675, effective July 31, 1986; preemptory amendment at 10 Ill. Reg. 14867, effective August 26, 1986; amended at 10 Ill. Reg. 15567, effective September 17, 1986; emergency amendment at 10 Ill. Reg. 17765, effective September 30, 1986, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 19132, effective October 28, 1986; preemptory amendment at 10 Ill. Reg. 21097, effective December 9, 1986; amended at 11 Ill. Reg. 648, effective December 22, 1986; preemptory amendment at 11 Ill. Reg. 3363, effective February 3, 1987; preemptory amendment at 11 Ill. Reg. 4388, effective February 27, 1987; preemptory amendment at 11 Ill. Reg. 6291, effective March 23, 1987; amended at 11 Ill. Reg. 5901, effective March 24, 1987; emergency amendment at 11 Ill. Reg. 8787, effective April 15, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 11830, effective July 1, 1987, for a maximum of 150 days; preemptory amendment at 11 Ill. Reg. 13675, effective July 29, 1987; amended at 11 Ill. Reg. 14984, effective August 27, 1987; preemptory amendment at 11 Ill. Reg. 15273, effective September 1, 1987; preemptory amendment at 11 Ill. Reg. 17919, effective October 19, 1987; preemptory amendment at 11 Ill. Reg. 19812, effective November 19, 1987; emergency amendment at 11 Ill. Reg. 20664, effective December 4, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 20778, effective December 11, 1987; preemptory amendment at 12 Ill. Reg. 3811, effective January 27, 1988; preemptory amendment at 12 Ill. Reg. 5459, effective March 3, 1988; amended at 12 Ill. Reg. 6073, effective March 21, 1988; emergency amendment at 12 Ill. Reg. 7734, effective April 15, 1988, for a maximum of 150 days; preemptory amendment at 12 Ill. Reg. 7783, effective April 14, 1988; preemptory amendment at 12 Ill. Reg. 8135, effective April 22, 1988; preemptory amendment at 12 Ill. Reg. 9745, effective May 23, 1988; emergency amendment at 12 Ill. Reg. 11778, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 12895, effective July 18, 1988, for a maximum of 150 days; preemptory amendment at 12 Ill. Reg. 13306, effective July 27, 1988; corrected at 12 Ill. Reg. 13359; amended at 12 Ill. Reg. 14630, effective

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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September 6, 1988; amended at 12 Ill. Reg. 20449, effective November 28, 1988; preemptory amendment at 12 Ill. Reg. 20584, effective November 28, 1988; preemptory amendment at 13 Ill. Reg. 8080, effective May 10, 1989; amended at 13 Ill. Reg. 8849, effective May 30, 1989; preemptory amendment at 13 Ill. Reg. 8970, effective May 26, 1989; emergency amendment at 13 Ill. Reg. 10967, effective June 20, 1989, for a maximum of 150 days; emergency amendment expired November 17, 1989; amended at 13 Ill. Reg. 11451, effective June 28, 1989; emergency amendment at 13 Ill. Reg. 11854, effective July 1, 1989, for a maximum of 150 days; corrected at 13 Ill. Reg. 12647; preemptory amendment at 13 Ill. Reg. 12887, effective July 24, 1989; amended at 13 Ill. Reg. 16950, effective October 20, 1989; amended at 13 Ill. Reg. 19221, effective December 12, 1989; amended at 14 Ill. Reg. 615, effective January 2, 1990; preemptory amendment at 14 Ill. Reg. 1627, effective January 11, 1990; amended at 14 Ill. Reg. 4455, effective March 12, 1990; preemptory amendment at 14 Ill. Reg. 7652, effective May 7, 1990; amended at 14 Ill. Reg. 10002, effective June 11, 1990; emergency amendment at 14 Ill. Reg. 11330, effective June 29, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14361, effective August 24, 1990; emergency amendment at 14 Ill. Reg. 15570, effective September 11, 1990, for a maximum of 150 days; emergency amendment expired February 8, 1991; corrected at 14 Ill. Reg. 16092; preemptory amendment at 14 Ill. Reg. 17098, effective September 26, 1990; amended at 14 Ill. Reg. 17189, effective October 2, 1990; amended at 14 Ill. Reg. 17189, effective October 19, 1990; amended at 14 Ill. Reg. 18719, effective November 13, 1990; preemptory amendment at 14 Ill. Reg. 18854, effective November 13, 1990; preemptory amendment at 15 Ill. Reg. 663, effective January 7, 1991; amended at 15 Ill. Reg. 3296, effective February 14, 1991; amended at 15 Ill. Reg. 4401, effective March 11, 1991; preemptory amendment at 15 Ill. Reg. 5100, effective March 20, 1991; preemptory amendment at 15 Ill. Reg. 5465, effective April 2, 1991; emergency amendment at 15 Ill. Reg. 10485, effective July 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 11080, effective July 19, 1991; amended at 15 Ill. Reg. 13080, effective August 21, 1991; amended at 15 Ill. Reg. 14210, effective September 23, 1991; emergency amendment at 16 Ill. Reg. 711, effective December 26, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 3450, effective February 20, 1992; preemptory amendment at 16 Ill. Reg. 5068, effective March 11, 1992; preemptory amendment at 16 Ill. Reg. 7056, effective April 20, 1992; emergency amendment at 16 Ill. Reg. 8239, effective May 19, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 8382, effective May 26, 1992; emergency amendment at 16 Ill. Reg. 13950, effective August 19, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14452, effective September 4, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 238, effective December 23, 1992; preemptory amendment at 17 Ill. Reg. 498, effective December 18, 1992; amended at 17 Ill. Reg. 590, effective January 4, 1993; amended at 17 Ill. Reg. 1819, effective February 2, 1993; amended at 17 Ill. Reg. 6441, effective April 8, 1993; emergency amendment at 17 Ill. Reg. 12900, effective July 22, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 13409, effective July 29, 1993; emergency amendment at 17 Ill. Reg. 13789, effective August 9, 1993,

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for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 14666, effective August 26, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 19103, effective October 25, 1993; emergency amendment at 17 Ill. Reg. 21858, effective December 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 22514, effective December 15, 1993; amended at 18 Ill. Reg. 227, effective December 17, 1993; amended at 18 Ill. Reg. 1107, effective January 18, 1994; amended at 18 Ill. Reg. 5146, effective March 21, 1994; preemptory amendment at 18 Ill. Reg. 9562, effective June 13, 1994; emergency amendment at 18 Ill. Reg. 11299, effective July 1, 1994, for a maximum of 150 days; preemptory amendment at 18 Ill. Reg. 13476, effective August 17, 1994; emergency amendment at 18 Ill. Reg. 14417, effective September 9, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16545, effective October 31, 1994; preemptory amendment at 18 Ill. Reg. 16708, effective October 28, 1994; amended at 18 Ill. Reg. 17191, effective November 21, 1994; amended at 19 Ill. Reg. 1024, effective January 24, 1995; preemptory amendment at 19 Ill. Reg. 2481, effective February 17, 1995; preemptory amendment at 19 Ill. Reg. 3073, effective February 17, 1995; amended at 19 Ill. Reg. 3456, effective March 7, 1995; preemptory amendment at 19 Ill. Reg. 5145, effective March 14, 1995; amended at 19 Ill. Reg. 6452, effective May 2, 1995; preemptory amendment at 19 Ill. Reg. 6688, effective May 1, 1995; amended at 19 Ill. Reg. 7841, effective June 1, 1995; amended at 19 Ill. Reg. 8156, effective June 12, 1995; amended at 19 Ill. Reg. 9096, effective June 27, 1995; emergency amendment at 19 Ill. Reg. 11954, effective August 1, 1995, for a maximum of 150 days; preemptory amendment at 19 Ill. Reg. 13979, effective September 19, 1995; preemptory amendment at 19 Ill. Reg. 15103, effective October 12, 1995; amended at 19 Ill. Reg. 16160, effective November 28, 1995; amended at 20 Ill. Reg. 308, effective December 22, 1995; emergency amendment at 20 Ill. Reg. 4060, effective February 27, 1996, for a maximum of 150 days; preemptory amendment at 20 Ill. Reg. 6334, effective April 22, 1996; preemptory amendment at 20 Ill. Reg. 7434, effective May 14, 1996; amended at 20 Ill. Reg. 8301, effective June 11, 1996; amended at 20 Ill. Reg. 8657, effective June 20, 1996; amended at 20 Ill. Reg. 9006, effective June 26, 1996; amended at 20 Ill. Reg. 9925, effective July 10, 1996; emergency amendment at 20 Ill. Reg. 10213, effective July 15, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 10841, effective August 5, 1996; preemptory amendment at 20 Ill. Reg. 13408, effective September 24, 1996; amended at 20 Ill. Reg. 15018, effective November 7, 1996; preemptory amendment at 20 Ill. Reg. 15092, effective November 7, 1996; emergency amendment at 21 Ill. Reg. 1023, effective January 6, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 1629, effective January 22, 1997; amended at 21 Ill. Reg. 5144, effective April 15, 1997; amended at 21 Ill. Reg. 6444, effective May 15, 1997; amended at 21 Ill. Reg. 7118, effective June 3, 1997; emergency amendment at 21 Ill. Reg. 10061, effective July 21, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 12859, effective September 8, 1997, for a maximum of 150 days; preemptory amendment at 21 Ill. Reg. 14267, effective October 14, 1997; preemptory amendment at 21 Ill. Reg. 14589, effective October 15, 1997; preemptory amendment at 21 Ill. Reg. 15030, effective November 10, 1997; amended at 21 Ill. Reg. 16344, effective December 9,

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1997; preemptory amendment at 21 Ill. Reg. 16465, effective December 4, 1997; preemptory amendment at 21 Ill. Reg. 17167, effective December 9, 1997; preemptory amendment at 22 Ill. Reg. 1593, effective December 22, 1997; amended at 22 Ill. Reg. 2580, effective January 14, 1998; preemptory amendment at 22 Ill. Reg. 4326, effective February 13, 1998; preemptory amendment at 22 Ill. Reg. 5108, effective February 26, 1998; preemptory amendment at 22 Ill. Reg. 5749, effective March 3, 1998; amended at 22 Ill. Reg. 6204, effective March 12, 1998; preemptory amendment at 22 Ill. Reg. 7053, effective April 1, 1998; preemptory amendment at 22 Ill. Reg. 7320, effective April 10, 1998; preemptory amendment at 22 Ill. Reg. 7692, effective April 20, 1998; emergency amendment at 22 Ill. Reg. 12607, effective July 2, 1998, for a maximum of 150 days; preemptory amendment at 22 Ill. Reg. 15489, effective August 7, 1998; amended at 22 Ill. Reg. 16158, effective August 31, 1998; preemptory amendment at 22 Ill. Reg. 19105, effective September 30, 1998; preemptory amendment at 22 Ill. Reg. 19943, effective October 27, 1998; preemptory amendment at 22 Ill. Reg. 20406, effective November 5, 1998; amended at 22 Ill. Reg. 20581, effective November 16, 1998; amended at 23 Ill. Reg. 664, effective January 1, 1999; preemptory amendment at 23 Ill. Reg. 730, effective December 29, 1998; emergency amendment at 23 Ill. Reg. 6533, effective May 10, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 7065, effective June 3, 1999; emergency amendment at 23 Ill. Reg. 8169, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 11020, effective August 26, 1999; amended at 23 Ill. Reg. 12429, effective September 21, 1999; preemptory amendment at 23 Ill. Reg. 12493, effective September 23, 1999; amended at 23 Ill. Reg. 12604, effective September 24, 1999; amended at 23 Ill. Reg. 13053, effective September 27, 1999; preemptory amendment at 23 Ill. Reg. 13132, effective October 1, 1999; amended at 23 Ill. Reg. 13570, effective October 26, 1999; amended at 23 Ill. Reg. 14020, effective November 15, 1999; amended at 24 Ill. Reg. 1025, effective January 7, 2000; preemptory amendment at 24 Ill. Reg. 3399, effective February 3, 2000; amended at 24 Ill. Reg. 3537, effective February 18, 2000; amended at 24 Ill. Reg. 6874, effective April 21, 2000; amended at 24 Ill. Reg. 7956, effective May 23, 2000; emergency amendment at 24 Ill. Reg. 10328, effective July 1, 2000, for a maximum of 150 days; emergency expired November 27, 2000; preemptory amendment at 24 Ill. Reg. 10767, effective July 3, 2000; amended at 24 Ill. Reg. 13384, effective August 17, 2000; preemptory amendment at 24 Ill. Reg. 14460, effective September 14, 2000; preemptory amendment at 24 Ill. Reg. 16700, effective October 30, 2000; preemptory amendment at 24 Ill. Reg. 17600, effective November 16, 2000; amended at 24 Ill. Reg. 18058, effective December 4, 2000; preemptory amendment at 24 Ill. Reg. 18444, effective December 1, 2000; amended at 25 Ill. Reg. 811, effective January 4, 2001; amended at 25 Ill. Reg. 2389, effective January 22, 2001; amended at 25 Ill. Reg. 4552, effective March 14, 2001; preemptory amendment at 25 Ill. Reg. 5067, effective March 21, 2001; amended at 25 Ill. Reg. 5618, effective April 4, 2001; amended at 25 Ill. Reg. 6655, effective May 11, 2001; amended at 25 Ill. Reg. 7151, effective May 25, 2001; preemptory amendment at 25 Ill. Reg. 8009, effective June 14, 2001; emergency amendment at 25 Ill. Reg. 9336, effective July 3, 2001, for a maximum of

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150 days; amended at 25 Ill. Reg. 9846, effective July 23, 2001; amended at 25 Ill. Reg. 12087, effective September 6, 2001; amended at 25 Ill. Reg. 15560, effective November 20, 2001; peremptory amendment at 25 Ill. Reg. 15671, effective November 15, 2001; amended at 25 Ill. Reg. 15974, effective November 28, 2001; emergency amendment at 26 Ill. Reg. 223, effective December 21, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 1143, effective January 17, 2002; amended at 26 Ill. Reg. 4127, effective March 5, 2002; peremptory amendment at 26 Ill. Reg. 4963, effective March 15, 2002; amended at 26 Ill. Reg. 6235, effective April 16, 2002; emergency amendment at 26 Ill. Reg. 7314, effective April 29, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 10425, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 10952, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13934, effective September 10, 2002; amended at 26 Ill. Reg. 14965, effective October 7, 2002; emergency amendment at 26 Ill. Reg. 16583, effective October 24, 2002, for a maximum of 150 days; emergency expired March 22, 2003; peremptory amendment at 26 Ill. Reg. 17280, effective November 18, 2002; amended at 26 Ill. Reg. 17374, effective November 25, 2002; amended at 26 Ill. Reg. 17987, effective December 9, 2002; amended at 27 Ill. Reg. 3261, effective February 11, 2003; expedited correction at 28 Ill. Reg. 6151, effective February 11, 2003; amended at 27 Ill. Reg. 8855, effective May 15, 2003; amended at 27 Ill. Reg. 9114, effective May 27, 2003; emergency amendment at 27 Ill. Reg. 10442, effective July 1, 2003, for a maximum of 150 days; emergency expired November 27, 2003; peremptory amendment at 27 Ill. Reg. 17433, effective November 7, 2003; amended at 27 Ill. Reg. 18560, effective December 1, 2003; peremptory amendment at 28 Ill. Reg. 1441, effective January 9, 2004; amended at 28 Ill. Reg. 2684, effective January 22, 2004; amended at 28 Ill. Reg. 6879, effective April 30, 2004; peremptory amendment at 28 Ill. Reg. 7323, effective May 10, 2004; amended at 28 Ill. Reg. 8842, effective June 11, 2004; peremptory amendment at 28 Ill. Reg. 9717, effective June 28, 2004; amended at 28 Ill. Reg. 12585, effective August 27, 2004; peremptory amendment at 28 Ill. Reg. 13011, effective September 8, 2004; peremptory amendment at 28 Ill. Reg. 13247, effective September 20, 2004; peremptory amendment at 28 Ill. Reg. 13656, effective September 27, 2004; emergency amendment at 28 Ill. Reg. 14174, effective October 15, 2004, for a maximum of 150 days; emergency expired March 13, 2005; peremptory amendment at 28 Ill. Reg. 14689, effective October 22, 2004; peremptory amendment at 28 Ill. Reg. 15336, effective November 15, 2004; peremptory amendment at 28 Ill. Reg. 16513, effective December 9, 2004; peremptory amendment at 29 Ill. Reg. 726, effective December 15, 2004; amended at 29 Ill. Reg. 1166, effective January 7, 2005; peremptory amendment at 29 Ill. Reg. 1385, effective January 4, 2005; peremptory amendment at 29 Ill. Reg. 1559, effective January 11, 2005; peremptory amendment at 29 Ill. Reg. 2050, effective January 19, 2005; peremptory amendment at 29 Ill. Reg. 4125, effective February 23, 2005; amended at 29 Ill. Reg. 5375, effective April 4, 2005; peremptory amendment at 29 Ill. Reg. 6105, effective April 14, 2005; peremptory amendment at 29 Ill. Reg. 7217, effective May 6, 2005; peremptory amendment at 29 Ill. Reg. 7840, effective May 10, 2005; amended at 29 Ill. Reg. 8110, effective May 23, 2005; peremptory amendment at

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29 Ill. Reg. 8214, effective May 23, 2005; preemptory amendment at 29 Ill. Reg. 8418, effective June 1, 2005; amended at 29 Ill. Reg. 9319, effective July 1, 2005; preemptory amendment at 29 Ill. Reg. 12076, effective July 15, 2005; preemptory amendment at 29 Ill. Reg. 13265, effective August 11, 2005; amended at 29 Ill. Reg. 13540, effective August 22, 2005; preemptory amendment at 29 Ill. Reg. 14098, effective September 2, 2005; amended at 29 Ill. Reg. 14166, effective September 9, 2005; amended at 29 Ill. Reg. 19551, effective November 21, 2005; emergency amendment at 29 Ill. Reg. 20554, effective December 2, 2005, for a maximum of 150 days; preemptory amendment at 29 Ill. Reg. 20693, effective December 12, 2005; preemptory amendment at 30 Ill. Reg. 623, effective December 28, 2005; preemptory amendment at 30 Ill. Reg. 1382, effective January 13, 2006; amended at 30 Ill. Reg. 2289, effective February 6, 2006; preemptory amendment at 30 Ill. Reg. 4157, effective February 22, 2006; preemptory amendment at 30 Ill. Reg. 5687, effective March 7, 2006; preemptory amendment at 30 Ill. Reg. 6409, effective March 30, 2006; amended at 30 Ill. Reg. 7857, effective April 17, 2006; amended at 30 Ill. Reg. 9438, effective May 15, 2006; preemptory amendment at 30 Ill. Reg. 10153, effective May 18, 2006; preemptory amendment at 30 Ill. Reg. 10508, effective June 1, 2006; amended at 30 Ill. Reg. 11336, effective July 1, 2006; emergency amendment at 30 Ill. Reg. 12340, effective July 1, 2006, for a maximum of 150 days; preemptory amendment at 30 Ill. Reg. 12418, effective July 1, 2006; amended at 30 Ill. Reg. 12761, effective July 17, 2006; preemptory amendment at 30 Ill. Reg. 13547, effective August 1, 2006; preemptory amendment at 30 Ill. Reg. 15059, effective September 5, 2006; preemptory amendment at 30 Ill. Reg. 16439, effective September 27, 2006; emergency amendment at 30 Ill. Reg. 16626, effective October 3, 2006, for a maximum of 150 days; preemptory amendment at 30 Ill. Reg. 17603, effective October 20, 2006; amended at 30 Ill. Reg. 18610, effective November 20, 2006; preemptory amendment at 30 Ill. Reg. 18823, effective November 21, 2006; preemptory amendment at 31 Ill. Reg. 230, effective December 20, 2006; emergency amendment at 31 Ill. Reg. 1483, effective January 1, 2007, for a maximum of 150 days; preemptory amendment at 31 Ill. Reg. 2485, effective January 17, 2007; preemptory amendment at 31 Ill. Reg. 4445, effective February 28, 2007; amended at 31 Ill. Reg. 4982, effective March 15, 2007; preemptory amendment at 31 Ill. Reg. 7338, effective May 3, 2007; amended at 31 Ill. Reg. 8901, effective July 1, 2007; emergency amendment at 31 Ill. Reg. 10056, effective July 1, 2007, for a maximum of 150 days; preemptory amendment at 31 Ill. Reg. 10496, effective July 6, 2007; preemptory amendment at 31 Ill. Reg. 12335, effective August 9, 2007; emergency amendment at 31 Ill. Reg. 12608, effective August 16, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 13220, effective August 30, 2007, for a maximum of 150 days; preemptory amendment at 31 Ill. Reg. 13357, effective August 29, 2007; amended at 31 Ill. Reg. 13981, effective September 21, 2007; preemptory amendment at 31 Ill. Reg. 14331, effective October 1, 2007; amended at 31 Ill. Reg. 16094, effective November 20, 2007; amended at 31 Ill. Reg. 16792, effective December 13, 2007; preemptory amendment at 32 Ill. Reg. 598, effective December 27, 2007; amended at 32 Ill. Reg. 1082, effective January 11, 2008; preemptory amendment at 32 Ill. Reg. 3095,

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effective February 13, 2008; preemptory amendment at 32 Ill. Reg. 6097, effective March 25, 2008; preemptory amendment at 32 Ill. Reg. 7154, effective April 17, 2008; expedited correction at 32 Ill. Reg. 9747, effective April 17, 2008; preemptory amendment at 32 Ill. Reg. 9360, effective June 13, 2008; amended at 32 Ill. Reg. 9881, effective July 1, 2008; preemptory amendment at 32 Ill. Reg. 12065, effective July 9, 2008; preemptory amendment at 32 Ill. Reg. 13861, effective August 8, 2008; preemptory amendment at 32 Ill. Reg. 16591, effective September 24, 2008; preemptory amendment at 32 Ill. Reg. 16872, effective October 3, 2008; preemptory amendment at 32 Ill. Reg. 18324, effective November 14, 2008; preemptory amendment at 33 Ill. Reg. 98, effective December 19, 2008; amended at 33 Ill. Reg. 2148, effective January 26, 2009; preemptory amendment at 33 Ill. Reg. 3530, effective February 6, 2009; preemptory amendment at 33 Ill. Reg. 4202, effective February 26, 2009; preemptory amendment at 33 Ill. Reg. 5501, effective March 25, 2009; preemptory amendment at 33 Ill. Reg. 6354, effective April 15, 2009; preemptory amendment at 33 Ill. Reg. 6724, effective May 1, 2009; preemptory amendment at 33 Ill. Reg. 9138, effective June 12, 2009; emergency amendment at 33 Ill. Reg. 9432, effective July 1, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 10211, effective July 1, 2009; preemptory amendment at 33 Ill. Reg. 10823, effective July 2, 2009; preemptory amendment at 33 Ill. Reg. 11082, effective July 10, 2009; preemptory amendment at 33 Ill. Reg. 11698, effective July 23, 2009; preemptory amendment at 33 Ill. Reg. 11895, effective July 31, 2009; preemptory amendment at 33 Ill. Reg. 12872, effective September 3, 2009; amended at 33 Ill. Reg. 14944, effective October 26, 2009; preemptory amendment at 33 Ill. Reg. 16598, effective November 13, 2009; preemptory amendment at 34 Ill. Reg. 305, effective December 18, 2009; emergency amendment at 34 Ill. Reg. 957, effective January 1, 2010, for a maximum of 150 days; preemptory amendment at 34 Ill. Reg. 1425, effective January 5, 2010; preemptory amendment at 34 Ill. Reg. 3684, effective March 5, 2010; preemptory amendment at 34 Ill. Reg. 5776, effective April 2, 2010; preemptory amendment at 34 Ill. Reg. 6214, effective April 16, 2010; amended at 34 Ill. Reg. 6583, effective April 30, 2010; preemptory amendment at 34 Ill. Reg. 7528, effective May 14, 2010; amended at 34 Ill. Reg. 7645, effective May 24, 2010; preemptory amendment at 34 Ill. Reg. 7947, effective May 26, 2010; preemptory amendment at 34 Ill. Reg. 8633, effective June 18, 2010; amended at 34 Ill. Reg. 9759, effective July 1, 2010; preemptory amendment at 34 Ill. Reg. 10536, effective July 9, 2010; preemptory amendment at 34 Ill. Reg. 11864, effective July 30, 2010; emergency amendment at 34 Ill. Reg. 12240, effective August 9, 2010, for a maximum of 150 days; preemptory amendment at 34 Ill. Reg. 13204, effective August 26, 2010; preemptory amendment at 34 Ill. Reg. 13657, effective September 8, 2010; preemptory amendment at 34 Ill. Reg. 15897, effective September 30, 2010; preemptory amendment at 34 Ill. Reg. 18912, effective November 15, 2010; preemptory amendment at 34 Ill. Reg. 19582, effective December 3, 2010; amended at 35 Ill. Reg. 765, effective December 30, 2010; emergency amendment at 35 Ill. Reg. 1092, effective January 1, 2011, for a maximum of 150 days; preemptory amendment at 35 Ill. Reg. 2465, effective January 19, 2011; preemptory amendment at 35 Ill. Reg. 3577, effective February

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10, 2011; emergency amendment at 35 Ill. Reg. 4412, effective February 23, 2011, for a maximum of 150 days; preemptory amendment at 35 Ill. Reg. 4803, effective March 11, 2011; emergency amendment at 35 Ill. Reg. 5633, effective March 15, 2011, for a maximum of 150 days; preemptory amendment at 35 Ill. Reg. 5677, effective March 18, 2011; amended at 35 Ill. Reg. 8419, effective May 23, 2011; amended at 35 Ill. Reg. 11245, effective June 28, 2011; emergency amendment at 35 Ill. Reg. 11657, effective July 1, 2011, for a maximum of 150 days; emergency expired November 27, 2011; preemptory amendment at 35 Ill. Reg. 12119, effective June 29, 2011; preemptory amendment at 35 Ill. Reg. 13966, effective July 29, 2011; preemptory amendment at 35 Ill. Reg. 15178, effective August 29, 2011; emergency amendment at 35 Ill. Reg. 15605, effective September 16, 2011, for a maximum of 150 days; preemptory amendment at 35 Ill. Reg. 15640, effective September 15, 2011; preemptory amendment at 35 Ill. Reg. 19707, effective November 23, 2011; amended at 35 Ill. Reg. 20144, effective December 6, 2011; amended at 36 Ill. Reg. 153, effective December 22, 2011; preemptory amendment at 36 Ill. Reg. 564, effective December 29, 2011; preemptory amendment at 36 Ill. Reg. 3957, effective February 24, 2012; preemptory amendment at 36 Ill. Reg. 4158, effective March 5, 2012; preemptory amendment at 36 Ill. Reg. 4437, effective March 9, 2012; amended at 36 Ill. Reg. 4707, effective March 19, 2012; amended at 36 Ill. Reg. 8460, effective May 24, 2012; preemptory amendment at 36 Ill. Reg. 10518, effective June 27, 2012; emergency amendment at 36 Ill. Reg. 11222, effective July 1, 2012, for a maximum of 150 days; preemptory amendment at 36 Ill. Reg. 13680, effective August 15, 2012; preemptory amendment at 36 Ill. Reg. 13973, effective August 22, 2012; preemptory amendment at 36 Ill. Reg. 15498, effective October 16, 2012; amended at 36 Ill. Reg. 16213, effective November 1, 2012; preemptory amendment at 36 Ill. Reg. 17138, effective November 20, 2012; preemptory amendment at 37 Ill. Reg. 3408, effective March 7, 2013; amended at 37 Ill. Reg. 4750, effective April 1, 2013; preemptory amendment at 37 Ill. Reg. 5925, effective April 18, 2013; preemptory amendment at 37 Ill. Reg. 9563, effective June 19, 2013; amended at 37 Ill. Reg. 9939, effective July 1, 2013.

## SUBPART A: NARRATIVE

**Section 310.45 Comparison of Pay Grades or Salary Ranges Assigned to Classifications**

- a) What Classifications to Compare When an Employee Moves – The movement of an employee subject to the Personnel Code to a vacant position (subject to the Personnel Code) is between two positions. The employee moves from the former position to the targeted position. The targeted position may be the former position allocated to a different classification title (80 Ill. Adm. Code 320.80) or may be the former position assigned substantial additional responsibilities in the same broad-band title (Section 310.495(c)). The former and targeted positions have the same or different classification titles. The former position is in the former

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classification and the targeted title is in the targeted classification. The former and targeted classifications are used in the comparison when an employee moves.

## b) Definitions of Employee Movements –

1) When the Former and Targeted Classification Titles are the Same – When the former and targeted classification titles are the same, the employee movement is an interim assignment (80 Ill. Adm. Code 302.150(j)), a transfer (80 Ill. Adm. Code 302.400), geographical transfer (80 Ill. Adm. Code 302.430) or where in the broad-band classification title the targeted position has substantial additional responsibilities compared to the former position (Section 310.495(c)).

2) When the Former and Targeted Classification Titles are Different – When the former and targeted classification titles are different, the employee movement is an interim assignment (80 Ill. Adm. Code 302.150(j)), a transfer (80 Ill. Adm. Code 302.400), geographical transfer (80 Ill. Adm. Code 302.430), demotion (80 Ill. Adm. Code 302.470), voluntary reduction (80 Ill. Adm. Code 302.500), promotion (Sections 310.50 and 310.500), based on the position being allocated to another class (80 Ill. Adm. Code 301.20 and 301.41) or based on the positions in a class being reclassified (Sections 310.50 and 310.500).

c) What to Compare in Each Classification – This pertains whether ~~Whether~~ comparing former and targeted classifications, the pay grades or salary ranges assigned to the former and targeted classifications, or the maximum permissible salary or rate assigned to the former and targeted classifications, ~~use the highest of the maximum base salaries in the regular pension formula pay grades or salary ranges assigned to the positions established inside the geographical limits of the State of Illinois for each classification. (Out of state rates in Section 310.495 are never used in the comparison.)~~

1) When the Former and Targeted Classification Titles are the Same – When the former and targeted classification titles are the same, no comparison beyond the titles, which are the same, is needed.

2) When Both Former and Targeted Classifications are Different – When both former and targeted classifications are different, determine whether

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both classes are whole, divided or one is whole and one is divided. The definitions for whole and divided classes are found in Section 310.50.

- A) When Both Classes are Whole – When both classes are whole, follow the flow chart provided in Appendix C.Illustration A by beginning with the oval with the word start in it, move through the flow chart by the arrows based on the information known about the two classes and finally reaching the diamond shape indicating what to compare. The definitions of bargaining unit and bargaining representative are found in Section 310.50. In that same Section, the definition of pay plan code assists in identifying whether regular or alternative rates are assigned to the classes listed in the ALPHABETIC INDEX OF POSITION TITLES. The ALPHABETIC INDEX OF POSITION TITLES provides the highest rates.
- B) When One Class is Whole and One Class is Divided – When one class is whole and one class is divided, follow the flow chart provided in Appendix C.Illustration B by beginning with the oval with the word start in it, move through the flow chart by the arrows based on the information known about the two classes and finally reaching the diamond shape indicating what to compare. The definitions of bargaining unit and bargaining representative are found in Section 310.50. In that same Section, the definition of pay plan code assists in identifying whether regular or alternative rates are assigned to the classes as listed in the ALPHABETIC INDEX OF POSITION TITLES. The ALPHABETIC INDEX OF POSITION TITLES provides the highest rates.
- C) When Both Classes are Divided – When both classes are divided, follow the flow chart provided in Appendix C.Illustration C by beginning with the oval with the word start in it, move through the flow chart by the arrows based on the information known about the two classes and finally reaching the diamond shape indicating what to compare. In moving through the flow chart, the classification titles containing an option (found in the definition of option in Section 310.50) do not apply. The definitions of bargaining unit and bargaining representative are found in Section 310.50. In that same Section, the definition of pay plan code assists in identifying

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whether regular or alternative rates are assigned to the classes as listed in the ALPHABETIC INDEX OF POSITION TITLES. The ALPHABETIC INDEX OF POSITION TITLES provides the highest rates.

- d) ~~What to Compare in Each Classification When Conditions in Subsection (e) Do Not Exist—If no regular pay formula pay grade or salary range exists for the classification, then identify the highest of the maximum base salaries in the alternative pension formula pay grades or salary ranges assigned to the positions established inside the geographical limits of the State of Illinois for the classification.~~ e) The Comparison Determines the Type of Employee Movement and Pay – Comparing the highest of the maximum base salaries set forth in subsection (c) ~~or subsection (d)~~ for each classification establishes whether the former classification is higher than, lower than or the same as the targeted classification. This information determines (or assists in determining) which type of employee movement in subsection (b) is occurring. From that determination, the pay treatment is set in following Sections of the Pay Plan.

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

**Section 310.47 In-Hiring Rate**

- a) Use – No employee in a position in which the position and/or the employee meet the criteria of an in-hiring rate receives less than the in-hiring rate. The in-hiring rate is used when a candidate only meets the minimum requirements of the class specification upon entry to State service (Section 310.100(b)(1), 310.490(b)(1) or 310.495(b)(1)), when an employee moves to a vacant position (Section 310.45) or when an MS salary range is assigned to a Trainee Program (Section 310.415(b)).
- b) Request – An agency head may request in writing that the Director of Central Management Services approve an in-hiring rate. The rate is a Step or dollar amount depending on whether the classification title is assigned to a negotiated pay grade, merit compensation salary range or broad-band salary range. The rate may be for the classification title or limited within the classification title to the agency, facilities, counties or other criteria. The supporting justifications for the requested in-hiring rate and the limitations are included in the agency request. An effective date may be included in the request.

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- c) Review – The Director of Central Management Services shall review the supporting justifications, the turnover rate, length of vacancies, and the currently filled positions for the classification title, and the market starting rates for similar classes, and consult with other agencies using the classification title.
- d) Approval – The Director of Central Management Services indicates in writing the approved in-hiring rate and effective date, which is either the date requested by the agency or the beginning of the next pay period after the approval.
- e) Implementation – In the classification title or within the limitations of the classification title, an employee paid below the in-hiring rate receives the in-hiring rate on the approved effective date. The in-hiring rate remains in effect for any employee entering the title or the limits within the title until the title is abolished or an agency request to rescind the in-hiring rate is approved by the Director of Central Management Services.
- f) Approved In-Hiring Rates –
- 1) Assigned to a pay grade or salary range –

<u>Title</u>	<u>Pay Grade or Salary Range</u>	<u>Effective Date</u>	<u>In- Hiring Rate</u>
Accounting & Fiscal Administration Career Trainee	RC-062-12	January 1, 2008	Step 3
Actuarial Examiner Trainee	RC-062-13	January 1, 2008	Step 4
Civil Engineer I	RC-063-15	January 1, 2008	Step 2
Commerce Commission Police Officer Trainee	MS-10	January 1, 2008	\$2,943
Correctional Officer	RC-006-09	January 1, 2008	Step 2
Correctional Officer Trainee	RC-006-05	January 1, 2008	Step 4
Environmental Engineer I	RC-063-15	January 1, 2008	Step 2
Environmental Protection Engineer I	RC-063-15	January 1, 2008	Step 5
Environmental Protection Engineer II	RC-063-17	January 1, 2008	Step 4
Financial Institutions Examiner Trainee	RC-062-13	January 1, 2008	Step 2

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Insurance Company Financial Examiner Trainee	RC-062-13	January 1, 2008	Step 4
Internal Auditor Trainee	MS-09	January 1, 2008	\$2,854
Revenue Special Agent Trainee	RC-062-14	January 1, 2008	Step 2
Terrorism Research Specialist Trainee	RC-062-14	January 1, 2008	Step 2

- 2) Assigned to a pay grade or salary range and based on the position's work location or employee's credential or residency –

<u>Title</u>	<u>Pay Grade or Salary Range</u>	<u>Location or Residency</u>	<u>Credential</u>	<u>Effective Date</u>	<u>In-Hiring Rate</u>
Civil Engineer Trainee	NR-916	None identified	Bachelor's degree in accredited civil engineering program	January 1, 2008	Add to minimum monthly rate \$40/quarter work experience up to 8
Civil Engineer Trainee	NR-916	None identified	Passed Engineering Intern exam	January 1, 2008	Add to minimum monthly rate \$60/month
Civil Engineer Trainee	NR-916	None identified	Master's degree	January 1, 2009	Add to minimum monthly rate \$60/month for each year experience up to two years
Clinical Psychology	RC-063- 18	None identified	Completed doctoral	February 1, 2008	Step 3

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Associate			dissertation		
Engineering Technician I, II, III and IV	NR-916	None identified	Completed 2	January 1,	\$2,705
			years of college in civil engineering or job related technical/science curriculum (60 semester/90 quarter hours credit)	2011 January 1, 2012	
Engineering Technician I, II, III and IV	NR-916	None identified	Completed 3	January 1,	\$2,600
			years of college in areas other than civil engineering or job related technical/science curriculum (90 semester/135 quarter hours credit)	2011 January 1, 2012	\$2,730
Engineering Technician I, II, III and IV	NR-916	None identified	Associate Degree from an accredited 2 year civil engineering technology program	January 1,	\$2,830
				2011 January 1, 2012	\$2,975
Engineering Technician I, II, III and IV	NR-916	None identified	Completed 3	January 1,	\$2,830
			years of college courses in civil engineering or job related technical/science curriculum (90 semester/135qua	2011 January 1, 2012	\$2,975

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rter hours credit)

Engineering Technician I, II, III and IV	NR-916	None identified	Completed 4 years of college courses in areas other than civil engineering or job related technical/science curriculum (120 semester/180 quarter hours credit)	January 1, 2011	\$2,705
				January 1, 2012	\$2,845
Engineering Technician I, II, III and IV	NR-916	None identified	Completed 4 years of college in civil engineering or job related technical/science curriculum (120 semester/180 quarter hours credit includes appointees from unaccredited engineering programs and those who have not yet obtained a degree)	January 1, 2011	\$2,945
				January 1, 2012	\$3,095
Engineering Technician I, II,	NR-916	None identified	Bachelor of Science Degree	January 1, 2011	\$3,340

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III and IV			from an accredited 4 year program in civil engineering technology, industrial technology, and construction technology	January 1, 2012	\$3,510
Forensic Scientist Trainee	RC-062-15	None identified	Meets minimum class requirements	January 1, 2008	Step 2
Forensic Scientist Trainee	RC-062-15	None identified	Completed Forensic Science Residency Program at the U of I – Chicago	January 1, 2008	Step 3
Information Services Intern	RC-063-15	Work outside Cook County	Computer Science degree at 4-year college	January 1, 2008	Step 4
Information Services Intern	RC-063-15	Work in Cook County	Computer Science degree at 4-year college	January 1, 2008	Step 6
Information Services Intern	RC-063-15	Work outside Cook County	Computer Science degree at 2-year technical school	January 1, 2008	Step 2
Information Services Intern	RC-063-15	Work in Cook County	Computer Science degree at 2-year technical school	January 1, 2008	Step 4
Information Services Intern	RC-063-15	Work in Cook County	Non-Computer Science degree	January 1, 2008	Step 3

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		County	at 4-year college		
Information Services Specialist I	RC-063-17	Work in Cook County	None identified beyond class requirements	January 1, 2008	Step 2
Juvenile Justice Specialist	RC-006-14	None identified	Master's degree	September 1, 2008	Step 2
Juvenile Justice Specialist Intern	RC-006-11	None identified	Master's degree	September 1, 2008	Step 2
Meat & Poultry Inspector Trainee	RC-033	Work in Regions 1 and 6	None identified beyond class requirements	January 1, 2008	Step 3
Physician Specialist, Option C	RC-063-MD-C	Work in Singer, McFarland, Zeller, Choate, Chester, Alton, Murray, and Mabley facilities	None identified beyond class requirements	January 1, 2008	Step 5
Physician Specialist, Option D	RC-063-MD-D	Work in Singer, McFarland, Zeller, Choate, Chester, Alton, Murray, and Mabley facilities	None identified beyond class requirements	January 1, 2008	Step 5

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Products & Standards Inspector Trainee	MS-09	Work in Cook, DuPage, Lake, Kane, and Will counties	None identified beyond class requirements	January 1, 2008	\$3,057
Products & Standards Inspector Trainee	MS-09	Work in counties outside Cook, DuPage, Lake, Kane, and Will counties	None identified beyond class requirements	January 1, 2008	\$2,854
Revenue Auditor Trainee	RC-062-12	Work in IL	None identified beyond class requirements	January 1, 2008	Step 5
Revenue Auditor Trainee	RC-062-15	See Note in Appendix A Table W	None identified beyond class requirements	January 1, 2008	Step 5
Revenue Auditor Trainee	RC-062-13	States other than IL and not assigned to RC-062-15	None identified beyond class requirements	January 1, 2008	Step 5
Security Therapy Aide Trainee	RC-009-13	Work in Joliet Treatment and Detention Facility	None identified beyond class requirements	January 1, 2008	Step 5
Telecommunicator	RC-014-12	Work in District 2	None identified beyond class	January 1, 2008	Step 2

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			requirements		
Telecommunicator Trainee	RC-014- 10	Work in Kane County	None identified beyond class requirements	January 1, 2008	Step 3
Telecommunicator Trainee	RC-014- 10	Work in Cook County	None identified beyond class requirements	January 1, 2008	Step 7

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

### Section 310.50 Definitions

The following definitions of terms are for purposes of clarification only. They affect the Schedule of Rates (Subpart B), and Negotiated Rates of Pay (Appendix A). Section 310.500 contains definitions of terms applying specifically to the Merit Compensation System.

"Adjustment in Salary" – A change in salary rate occasioned by a previously committed error or oversight, or required in the best interest of the State as defined in Sections 310.80 and 310.90.

"Bargaining Representative" – The sole and exclusive labor organization (union, chapter, lodge or association) recognized, as noted in an agreement with the State of Illinois, to negotiate for one or more bargaining units and may include one or more locals.

"Bargaining Unit" – The sole and exclusive labor organization that represents and includes at least one position and its appointed employee as specified in a Certification of Representative, Certification of Clarified Unit or corrected certification issued by the Illinois Labor Relations Board as authorized by the Illinois Public Labor Relations Act [5 ILCS 315/6(c) and 9(d)].

"Base Salary" – A dollar amount of pay specifically designated in the Negotiated Rates of Pay (Appendix A) or Schedule of Rates (Subpart B). Base salary does not include commission, incentive pay, bilingual pay, longevity pay, overtime pay, shift differential pay or deductions for time not worked.

"Bilingual Pay" – The dollar amount per month, or percentage of the employee's monthly base salary, paid in addition to the employee's base salary when the

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individual position held by the employee has a job description that requires the use of sign language, Braille, or another second language (e.g., Spanish), or that requires the employee to be bilingual.

"Classification" – The classification established based on the Personnel Code [20 ILCS 415/8a(1)] and to which one or more positions are allocated based upon similarity of duties performed, responsibilities assigned and conditions of employment. Classification may be abbreviated to "class" and referred to by its title or title code.

"Class Specification" – The document comprising the title, title code, effective date, distinguishing features of work, illustrative examples of work and desirable requirements.

"Comparable Classes" – Two or more classes that are in the same pay grade.

"Creditable Service" – All service in full or regularly scheduled part-time pay status beginning with the date of initial employment or the effective date of the last salary increase that was at least equivalent to a full step.

"Demotion" – The assignment for cause of an employee to a vacant position in a class in a lower pay grade than the former class.

"Differential" – The additional compensation added to the base salary of an employee resulting from conditions of employment imposed on the employee during normal schedule of work.

"Divided Class" – The classification established by the Personnel Code [20 ILCS 415/8a(1)], represented by more than one bargaining unit as certified by the Illinois Labor Relations Board and to which more than one bargaining unit pay grade is assigned. The divided classes effective February 21, 2013 are:

<u>Title</u>	<u>Title Code</u>
<u>Apparel/Dry Goods Specialist III</u>	<u>01233</u>
<u>Bridge Mechanic</u>	<u>05310</u>
<u>Bridge Tender</u>	<u>05320</u>
<u>Civil Engineer I</u>	<u>07601</u>
<u>Civil Engineer II</u>	<u>07602</u>
<u>Civil Engineer III</u>	<u>07603</u>

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<u>Clinical Laboratory Associate</u>	<u>08200</u>
<u>Clinical Laboratory Technician I</u>	<u>08215</u>
<u>Clinical Laboratory Technician II</u>	<u>08216</u>
<u>Educator</u>	<u>13100</u>
<u>Educator Aide</u>	<u>13130</u>
<u>Engineering Technician II</u>	<u>13732</u>
<u>Engineering Technician III</u>	<u>13733</u>
<u>Highway Maintainer</u>	<u>18639</u>
<u>Highway Maintenance Lead Worker</u>	<u>18659</u>
<u>Housekeeper II</u>	<u>19602</u>
<u>Labor Maintenance Lead Worker</u>	<u>22809</u>
<u>Laboratory Assistant</u>	<u>22995</u>
<u>Laboratory Associate I</u>	<u>22997</u>
<u>Laboratory Associate II</u>	<u>22998</u>
<u>Laborer (Maintenance)</u>	<u>23080</u>
<u>Licensed Practical Nurse I</u>	<u>23551</u>
<u>Licensed Practical Nurse II</u>	<u>23552</u>
<u>Maintenance Equipment Operator</u>	<u>25020</u>
<u>Maintenance Worker</u>	<u>25500</u>
<u>Pest Control Operator</u>	<u>31810</u>
<u>Power Shovel Operator (Maintenance)</u>	<u>33360</u>
<u>Property and Supply Clerk II</u>	<u>34792</u>
<u>Property and Supply Clerk III</u>	<u>34793</u>
<u>Public Service Administrator</u>	<u>37015</u>
<u>Senior Public Service Administrator</u>	<u>40070</u>
<u>Silk Screen Operator</u>	<u>41020</u>
<u>Social Service Aide Trainee</u>	<u>41285</u>
<u>Storekeeper I</u>	<u>43051</u>
<u>Storekeeper II</u>	<u>43052</u>
<u>Storekeeper III</u>	<u>43053</u>
<u>Stores Clerk</u>	<u>43060</u>

"Entrance Base Salary" – The initial base salary assigned to an employee upon entering State service.

"Hourly Pay Grade" – The designation for hourly negotiated pay rates is "H".

"In Between Pay Grade" – The designation for negotiated pay rates in between pay grades is ".5".

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"In-hiring Rate" – An in-hiring rate is a minimum rate/step for a class that is above the normal minimum of the range, as approved by the Director of Central Management Services after a review of competitive market starting rates for similar classes.

"Option" – The denotation of directly-related education, experience and/or knowledge, skills and abilities required to qualify for the position allocated to the classification. The requirements may meet or exceed the requirements indicated in the classification specification. The following options are for the Public Service Administrator classification and have a negotiated pay grade and/or a broad-banded salary range assigned:

- 1 = General Administration/Business Marketing/Labor/Personnel
- 2 = Fiscal Management/Accounting/Budget/Internal Audit/Insurance/Financial
- 2B = Financial Regulatory
- 2C = Economist
- 3 = Management Information System/Data Processing/Telecommunications
- 3J = Java Application Developer
- 3N = Wide Area Networks
- 4 = Physical Sciences/Environment
- 6 = Health and Human Services
- 6B = Day Care Quality Assurance
- 6C = Health Statistics
- 6D = Health Promotion/Disease Prevention
- 6E = Laboratory Specialist
- 6F = Infectious Disease
- 6G = Disaster/Emergency Medical Services
- 7 = Law Enforcement/Correctional
- 8A = Special License – Architect License
- 8B = Special License – Boiler Inspector License
- 8C = Special License – Certified Public Accountant
- 8D = Special License – Federal Communications Commission License/National Association of Business and Educational Radio
- 8E = Special License – Engineer (Professional)
- 8F = Special License – Federal Aviation Administration Medical

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## Certificate/First Class

- 8G = Special License – Clinical Professional Counselor
- 8H = Special License – Environmental Health Practitioner
- 8I = Special License – Professional Land Surveyor License
- 8J = Special License – Registered American Dietetic Association/Public Health Food Service Sanitation Certificate/Licensed Dietitian
- 8K = Special License – Licensed Psychologist
- 8L = Special License – Law License
- 8N = Special License – Registered Nurse License
- 8O = Special License – Occupational Therapist License
- 8P = Special License – Pharmacist License
- 8Q = Special License – Religious Ordination by Recognized Commission
- 8R = Special License – Dental Hygienist
- 8S = Special License – Social Worker/Clinical Social Worker
- 8T = Special License – Administrative Certificate issued by the Illinois State Board of Education
- 8U = Special License – Physical Therapist License
- 8V = Special License – Audiologist License
- 8W = Special License – Speech-Language Pathologist License
- 8X = Special License – Blaster Certificate
- 8Y = Special License – Plumbing License
- 8Z = Special License – Special Metrologist Training
- 9A = Special License – Certified Internal Auditor
- 9B = Special License – Certified Information Systems Auditor
- 9G = Special License – Registered Professional Geologist License
- 9T = Teamster Management Information Systems, effective December 30, 2009 through February 1, 2011

The following options are for the Senior Public Service Administrator classification and have a negotiated pay grade and/or a broad-banded salary range assigned:

- 1 = General Administration/Business Marketing/Labor/Personnel
- 2 = Fiscal Management/Accounting/Budget/ Internal Audit/Insurance/Financial
- 2B = Financial Regulatory

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- 3 = Management Information System/Data Processing/Telecommunications
- 4 = Physical Sciences/Environment
- 5 = Agriculture/Conservation
- 6 = Health and Human Services
- 7 = Law Enforcement/Correctional
- 8A = Special License – Architect License
- 8B = Special License – Boiler Inspector License
- 8C = Special License – Certified Public Accountant/Certified Internal Auditor/Certified Information Systems Auditor
- 8D = Special License – Dental License
- 8E = Special License – Engineer (Professional)
- 8F = Special License – Clinical Professional Counseling
- 8G = Special License – Geologist License
- 8H = Special License – Environmental Health Practitioner
- 8I = Special License – Illinois Auctioneer License
- 8K = Special License – Licensed Psychologist
- 8L = Special License – Law License (Illinois)
- 8M = Special License – Veterinary Medicine License
- 8N = Special License – Nurse (Registered IL) License
- 8O = Special License – Occupational Therapist License
- 8P = Special License – Pharmacist License
- 8Q = Special License – Nursing Home Administration License
- 8R = Special License – Real Estate Brokers License
- 8S = Special License – Social Worker/Clinical Social Worker
- 8T = Special License – Illinois Teaching Certificate (Type 75)/General Administrative Certificate (Type 61) issued by the Illinois State Board of Education
- 8Z = Special License – Certified Real Estate Appraisal License

Other classification titles contain an option and the option also may denote differences in the distinguishing features of work indicated in the classification specification. The classification titles containing an option are:

- Children and Family Service Intern, Option 1
- Children and Family Service Intern, Option 2
- Health Services Investigator I, Option A – General

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Health Services Investigator I, Option B – Controlled Substance Inspector  
Health Services Investigator II, Option A – General  
Health Services Investigator II, Option B – Controlled Substance  
Inspector  
Health Services Investigator II, Option C – Pharmacy  
Health Services Investigator II, Option D – Pharmacy/Controlled  
Substance Inspector  
Juvenile Justice Youth and Family Specialist Option 1  
Juvenile Justice Youth and Family Specialist Option 2  
Medical Administrator I Option C  
Medical Administrator I Option D  
Medical Administrator II Option C  
Medical Administrator II Option D  
Physician Specialist – Option A  
Physician Specialist – Option B  
Physician Specialist – Option C  
Physician Specialist – Option D  
Physician Specialist – Option E  
Research Fellow, Option B

"Pay Grade" – The numeric designation used for an established set of steps or salary range.

"Pay Plan Code" – The designation used in assigning a specific salary rate based on a variety of factors associated with the position. Pay Plan Codes used in the Pay Plan are:

- B = Negotiated regular pension formula rate for the State of Illinois
- E = Educator title AFSCME negotiated 12-month regular pension formula rate for the State of Illinois
- J = Negotiated regular pension formula rate for states other than Illinois, California or New Jersey
- L = Educator title AFSCME negotiated 12-month alternative pension formula rate for the State of Illinois
- M = Educator title AFSCME negotiated 9-month regular pension formula rate at the Illinois School for the Visually Impaired

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- N = Educator title Illinois Federation of Teachers negotiated 9-month regular pension formula rate for the Illinois School for the Deaf
- O = Educator title AFSCME negotiated 9-month regular pension formula rate at the Illinois Center for Rehabilitation and Education-Roosevelt
- P = Educator title AFSCME negotiated 12-month maximum-security institution rate for the State of Illinois
- Q = Negotiated alternative pension formula rate for the State of Illinois
- S = Negotiated maximum-security institution rate for the State of Illinois
- U = Negotiated regular pension formula rate for the state of California or New Jersey

"Promotion" – The appointment of an employee, with the approval of the agency and the Department of Central Management Services, to a vacant position in a class in a higher pay grade than the former class.

"Reallocation" – The change in the classification of a position resulting from significant changes in assigned duties and responsibilities.

"Reclassification" – The assignment of a position or positions to a different classification based on creation of a new classification or the revision of existing class specification, and approved by the Civil Service Commission.

"Reevaluation" – The assignment of a different pay grade to a class based upon change in relation to other classes or to the labor market.

"Salary Range" – The dollar value represented by Steps 1c through 8 of a pay grade assigned to a class title.

"Satisfactory Performance Increase" – An upward revision in the base salary from one designated step to the next higher step in the pay grade for that class as a result of having served the required amount of time at the former rate with not less than a satisfactory level of competence. (Satisfactory level of competence shall mean work, the level of which, in the opinion of the agency head, is above that typified by the marginal employee.)

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"Transfer" – The assignment of an employee to a vacant position having the same pay grade.

"Whole Class" – The classification established by the Personnel Code [20 ILCS 415/8a(1)], represented by no more than one bargaining unit as certified by the Illinois Labor Relations Board and to which no more than one bargaining unit pay grade is assigned.

"Work Year" – That period of time determined by the agency and filed with the Department of Central Management Services in accordance with 80 Ill. Adm. Code 303.300.

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

**Section 310.130 Effective Date**

This Pay Plan Narrative (Subpart A), Schedule of Rates (Subpart B), Merit Compensation System (Subpart C), Negotiated Rates of Pay (Appendix A), Merit Compensation System Salary Schedule (Appendix D), and Broad-Band Pay Range Classes Salary Schedule (Appendix G) shall be effective for Fiscal Year ~~2014~~2013.

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## SUBPART B: SCHEDULE OF RATES

**Section 310.220 Negotiated Rate**

- a) Rates by Geographic Area, Agency or Agency Area – The rate of pay for a class in any specific area or agency, or in a specific area for an agency, is established and approved by the Director of Central Management Services after having conducted negotiations for this purpose, or as certified as being correct and reported to the Director of Central Management Services by the Director of the Illinois Department of Labor for designated classifications.
- b) Rates for Positions Excluded from Bargaining Unit Representation – An employee occupying a position in a class normally subject to contract, but whose position is excluded from the bargaining unit, shall be assigned to the Merit Compensation System (Subpart C) and receive the rates, within the Merit Compensation System Salary Schedule (Appendix D) based on the salary range

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assigned to the classification title in Section 310.410, an out-of-state rate assigned to the classification title in Section 310.495 or within the Broad-Band Pay Range Classes Salary Schedule (Appendix G) based on the salary range assigned to the classification title.

- c) Rates for Higher Duties – As provided in certain collective bargaining agreements, an employee may be paid at an appropriate higher rate when assigned to perform the duties of a higher level position. Eligibility for and the amount of this pay will be as provided in the contract.
- d) Promotion from Step 8 – The employee shall be paid as provided in Section 310.80(d)(1)(A)(ii).
- e) To Locate Rates – The negotiated rates of pay for classifications in specified operating agencies, in specified agency facilities or with specified duties shall be as indicated in Appendix A, unless the rates are red-circled or frozen.
- f) Red-Circled Rates – Red-circled rates are the negotiated or arbitrator assigned base salaries not otherwise on a step in the pay grade assigned to a classification or in the Pay Plan. The base salaries may be above the pay grade's maximum base salary or between two base salaries on consecutive steps. An employee who takes a position in a Trainee Program (80 Ill. Adm. Code 302.170) classification that represents a reduction when comparing classifications (Section 310.45) shall receive the higher amount of either the in-hire rate or the base salary red-circled at the amount of the former classification. Upon completion of a trainee period, the employee who is promoted to a targeted title shall receive the rate on a step that results in a minimum of one dollar increase based on the difference between the two steps, which the red-circled rate is between, added to the red-circled rate. If through negotiation of a classification assignment to a pay grade where the base salary exceeds Step 8, the base salary shall be red-circled at its current rate and may receive contractual adjustments.

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## SUBPART C: MERIT COMPENSATION SYSTEM

**Section 310.410 Jurisdiction**

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The Merit Compensation System shall apply to classes of positions, or positions excluded from bargaining unit representation, designated below and Broad-Band classes in Appendix G. In addition, the classes are listed in the ALPHABETIC INDEX OF POSITION TITLES. Also see Section 310.495 for the application of the Merit Compensation System for those Broad-Band titles listed with their salary ranges in Appendix G.

<b>Title</b>	<b>Title Code</b>	<b>Salary Range</b>
Account Clerk I	00111	MS-03
Account Clerk II	00112	MS-04
Account Technician I	00115	MS-07
Account Technician II	00116	MS-09
Account Technician Trainee	00118	MS-04
Accountant	00130	MS-11
Accountant Advanced	00133	MS-14
Accountant Supervisor	00135	MS-19
Accounting and Fiscal Administration Career Trainee	00140	MS-09
Activity Program Aide I	00151	MS-04
Activity Program Aide II	00152	MS-05
Activity Therapist	00157	MS-12
Activity Therapist Coordinator	00160	MS-16
Activity Therapist Supervisor	00163	MS-23
Actuarial Assistant	00187	MS-14
Actuarial Examiner	00195	MS-14
Actuarial Examiner Trainee	00196	MS-10
Actuarial Senior Examiner	00197	MS-21
Actuary I	00201	MS-23
Actuary II	00202	MS-31
Actuary III	00203	MS-33
Administrative Assistant I	00501	MS-16
Administrative Assistant II	00502	MS-21
Administrative Services Worker Trainee	00600	MS-02
Agricultural Executive	00800	MS-23
Agricultural Land and Water Resources Supervisor	00811	MS-25
Agricultural Market News Assistant	00804	MS-09
Agricultural Marketing Generalist	00805	MS-11
Agricultural Marketing Reporter	00807	MS-19
Agricultural Marketing Representative	00810	MS-19
Agricultural Products Promoter	00815	MS-10

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Agriculture Land and Water Resource Specialist I	00831	MS-11
Agriculture Land and Water Resource Specialist II	00832	MS-16
Agriculture Land and Water Resource Specialist III	00833	MS-23
Aircraft Dispatcher	00951	MS-09
Aircraft Lead Dispatcher	00952	MS-11
Aircraft Pilot I	00955	MS-21
Aircraft Pilot II	00956	MS-28
Aircraft Pilot II – Dual Rating	00957	MS-29
Animal and Animal Products Investigator	01072	MS-11
Animal and Animal Products Investigator Trainee	01075	MS-09
Apiary Inspector	01215	MS-03
Apparel/Dry Goods Specialist I	01231	MS-04
Apparel/Dry Goods Specialist II	01232	MS-05
Apparel/Dry Goods Specialist III	01233	MS-10
Appraisal Specialist I	01251	MS-11
Appraisal Specialist II	01252	MS-14
Appraisal Specialist III	01253	MS-19
Appraisal Specialist Trainee	01255	MS-09
Arbitrator	01401	MS-33
Architect	01440	MS-28
Arson Investigations Trainee	01485	MS-12
Arson Investigator I	01481	MS-15
Arson Investigator II	01482	MS-20
Arts Council Associate	01523	MS-09
Arts Council Program Coordinator	01526	MS-19
Arts Council Program Representative	01527	MS-12
Assignment Coordinator	01530	MS-23
Assistant Automotive Shop Supervisor	01565	MS-11
Assistant Reimbursement Officer	02424	MS-05
Audio Visual Technician I	03501	MS-04
Audio Visual Technician II	03502	MS-06
Auto and Body Repairer	03680	MS-13
Automotive Attendant I	03696	MS-03
Automotive Attendant II	03697	MS-03
Automotive Mechanic	03700	MS-13
Automotive Parts Warehouse Specialist	03734	MS-11
Automotive Parts Warehouse	03730	MS-11

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Automotive Shop Supervisor	03749	MS-18
Bank Examiner I	04131	MS-14
Bank Examiner II	04132	MS-21
Bank Examiner III	04133	MS-28
Behavioral Analyst Associate	04355	MS-12
Behavioral Analyst I	04351	MS-16
Behavioral Analyst II	04352	MS-21
<u>Blasting Expert</u>	<u>04720</u>	<u>MS-27</u>
<u>Blasting Specialist</u>	<u>04725</u>	<u>MS-25</u>
<u>Blasting Supervisor</u>	<u>04730</u>	<u>MS-29</u>
Boat Safety Inspection Supervisor	04850	MS-22
Boiler Safety Specialist	04910	MS-26
Breath Alcohol Analysis Technician	05170	MS-15
Bridge Mechanic	05310	MS-17
Bridge Tender	05320	MS-18
Building Construction Inspector I	05541	MS-18
Building Construction Inspector II	05542	MS-20
Building Services Worker	05616	MS-05
Building/Grounds Laborer	05598	MS-08
Building/Grounds Lead I	05601	MS-10
Building/Grounds Lead II	05602	MS-12
Building/Grounds Maintenance Worker	05613	MS-09
Building/Grounds Supervisor	05605	MS-12
Business Administrative Specialist	05810	MS-14
Business Manager	05815	MS-19
Buyer	05900	MS-19
Buyer Assistant	05905	MS-07
<u>Cancer Registrar I</u>	<u>05951</u>	<u>MS-11</u>
Cancer Registrar II	05952	MS-14
<u>Cancer Registrar III</u>	<u>05953</u>	<u>MS-23</u>
<u>Cancer Registrar Assistant Manager</u>	<u>05954</u>	<u>MS-27</u>
<u>Cancer Registrar Manager</u>	<u>05955</u>	<u>MS-31</u>
Canine Specialist	06500	MS-20
Capital Development Board Account Technician	06515	MS-08
Capital Development Board Art In Architecture Technician	06533	MS-09
Capital Development Board Construction Support Analyst	06520	MS-08
Capital Development Board Media Technician	06525	MS-11

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Capital Development Board Project Technician	06530	MS-09
Cartographer III	06673	MS-28
Chaplain I	06901	MS-14
Chaplain II	06902	MS-21
Check Issuance Machine Operator	06920	MS-06
Check Issuance Machine Supervisor	06925	MS-08
Chemist I	06941	MS-14
Chemist II	06942	MS-21
Chemist III	06943	MS-25
Child Development Aide	07184	MS-07
Child Protection Advanced Specialist	07161	MS-21
Child Protection Associate Specialist	07162	MS-14
Child Protection Specialist	07163	MS-19
Child Support Specialist I	07198	MS-14
Child Support Specialist II	07199	MS-16
Child Support Specialist Trainee	07200	MS-09
Child Welfare Administrative Case Reviewer	07190	MS-28
Child Welfare Advanced Specialist	07215	MS-21
Child Welfare Associate Specialist	07216	MS-14
Child Welfare Court Facilitator	07196	MS-28
Child Welfare Nurse Specialist	07197	MS-22
Child Welfare Senior Specialist	07217	MS-28
Child Welfare Specialist	07218	MS-19
Child Welfare Staff Development Coordinator I	07201	MS-16
Child Welfare Staff Development Coordinator II	07202	MS-21
Child Welfare Staff Development Coordinator III	07203	MS-23
Child Welfare Staff Development Coordinator IV	07204	MS-28
Children and Family Service Intern, Option 1	07241	MS-09
Children and Family Service Intern, Option 2	07242	MS-12
Civil Engineer I	07601	MS-22
Civil Engineer II	07602	MS-26
Civil Engineer III	07603	MS-30
Civil Engineer IV	07604	MS-31
Civil Engineer Trainee	07607	MS-16
Clerical Trainee	08050	MS-01
Clinical Laboratory Associate	08200	MS-05
Clinical Laboratory Phlebotomist	08213	MS-04

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Clinical Laboratory Technician I	08215	MS-07
Clinical Laboratory Technician II	08216	MS-09
Clinical Laboratory Technologist I	08220	MS-19
Clinical Laboratory Technologist II	08221	MS-21
Clinical Laboratory Technologist Trainee	08229	MS-11
Clinical Pharmacist	08235	MS-32
Clinical Psychologist	08250	MS-29
Clinical Psychology Associate	08255	MS-19
Clinical Services Supervisor	08260	MS-31
Commerce Commission Police Officer I	08451	MS-18
Commerce Commission Police Officer II	08452	MS-22
Commerce Commission Police Officer Trainee	08455	MS-10
Commerce Commission Police Sergeant	08457	MS-24
Commodities Inspector	08770	MS-08
Communications Dispatcher	08815	MS-06
Communications Equipment Technician I	08831	MS-16
Communications Equipment Technician II	08832	MS-21
Communications Equipment Technician III	08833	MS-23
Communications Systems Specialist	08860	MS-29
Community Management Specialist I	08891	MS-12
Community Management Specialist II	08892	MS-16
Community Management Specialist III	08893	MS-21
Community Planner I	08901	MS-12
Community Planner II	08902	MS-16
Community Planner III	08903	MS-21
Compliance Officer	08919	MS-11
Conservation Education Representative	09300	MS-09
Conservation Grant Administrator I	09311	MS-19
Conservation Grant Administrator II	09312	MS-23
Conservation Grant Administrator III	09313	MS-28
Conservation Police Lieutenant	<del>09339</del> 09340	MS-23
Conservation Police Officer I	09341	MS-18
Conservation Police Officer II	09342	MS-19
Conservation Police Officer Trainee	09345	MS-06
Conservation Police Sergeant	09347	MS-22
Conservation/Historic Preservation Worker	09317	MS-01
Construction Program Assistant	09525	MS-09

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Construction Supervisor I	09561	MS-10
Construction Supervisor II	09562	MS-14
Cook I	09601	MS-04
Cook II	09602	MS-07
Correctional Casework Supervisor	09655	MS-25
Correctional Counselor I	09661	MS-12
Correctional Counselor II	09662	MS-16
Correctional Counselor III	09663	MS-21
Correctional Lieutenant	09673	MS-24
Correctional Officer	09675	MS-11
Correctional Officer Trainee	09676	MS-08
Correctional Sergeant	09717	MS-16
Corrections Apprehension Specialist	09750	MS-21
Corrections Clerk I	09771	MS-11
Corrections Clerk II	09772	MS-13
Corrections Clerk III	09773	MS-18
Corrections Food Service Supervisor I	09793	MS-13
Corrections Food Service Supervisor II	09794	MS-18
Corrections Food Service Supervisor III	09795	MS-21
Corrections Grounds Supervisor	09796	MS-16
Corrections Identification Supervisor	09800	MS-24
Corrections Identification Technician	09801	MS-13
Corrections Industries Marketing Representative	09803	MS-16
Corrections Industry Lead Worker	09805	MS-16
Corrections Industry Supervisor	09807	MS-21
Corrections Laundry Manager I	09808	MS-18
Corrections Laundry Manager II	09809	MS-20
Corrections Leisure Activities Specialist I	09811	MS-12
Corrections Leisure Activities Specialist II	09812	MS-16
Corrections Leisure Activities Specialist III	09813	MS-21
Corrections Leisure Activities Specialist IV	09814	MS-25
Corrections Locksmith	09818	MS-16
Corrections Maintenance Craftsman	09821	MS-16
Corrections Maintenance Supervisor	09822	MS-20
Corrections Maintenance Worker	09823	MS-12
Corrections Medical Technician	09824	MS-12
Corrections Nurse I	09825	MS-20

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Corrections Nurse II	09826	MS-25
Corrections Parole Agent	09842	MS-16
Corrections Residence Counselor I	09837	MS-13
Corrections Residence Counselor II	09838	MS-20
Corrections Senior Parole Agent	09844	MS-21
Corrections Supply Supervisor I	09861	MS-13
Corrections Supply Supervisor II	09862	MS-18
Corrections Supply Supervisor III	09863	MS-21
Corrections Transportation Officer I	09871	MS-13
Corrections Transportation Officer II	09872	MS-20
Corrections Utilities Operator	09875	MS-16
Corrections Vocational Instructor	09879	MS-16
Corrections Vocational School Supervisor	09880	MS-20
Court Reporter	09900	MS-12
Court Reporter Supervisor	09903	MS-26
Crime Scene Investigator	09980	MS-25
Criminal Intelligence Analyst I	10161	MS-19
Criminal Intelligence Analyst II	10162	MS-23
Criminal Intelligence Analyst Specialist	10165	MS-28
Criminal Justice Specialist I	10231	MS-14
Criminal Justice Specialist II	10232	MS-23
Criminal Justice Specialist Trainee	10236	MS-10
Curator Of The Lincoln Collection	10750	MS-14
Data Processing Administrative Specialist	11415	MS-11
Data Processing Assistant	11420	MS-04
Data Processing Operator	11425	MS-03
Data Processing Operator Trainee	11428	MS-02
Data Processing Specialist	11430	MS-09
Data Processing Supervisor I	11435	MS-08
Data Processing Supervisor II	11436	MS-11
Data Processing Supervisor III	11437	MS-19
Data Processing Technician	11440	MS-06
Data Processing Technician Trainee	11443	MS-04
Day Care Licensing Representative I	11471	MS-14
Day Care Licensing Representative II	11472	MS-19
Deck Hand	11500	MS-15
Dental Assistant	11650	MS-07

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Dental Hygienist	11700	MS-11
Dentist I	11751	MS-29
Dentist II	11752	MS-33
Developmental Disabilities Council Program Planner I	12361	MS-09
Developmental Disabilities Council Program Planner II	12362	MS-14
Developmental Disabilities Council Program Planner III	12363	MS-19
Dietary Manager I	12501	MS-14
Dietary Manager II	12502	MS-19
Dietitian	12510	MS-12
Disability Appeals Officer	12530	MS-28
Disability Claims Adjudicator I	12537	MS-14
Disability Claims Adjudicator II	12538	MS-19
Disability Claims Adjudicator Trainee	12539	MS-10
Disability Claims Analyst	12540	MS-25
Disability Claims Specialist	12558	MS-21
Disaster Services Planner	12585	MS-21
Document Examiner	12640	MS-28
Drafting Worker	12749	MS-08
Drug Compliance Investigator	12778	MS-31
Economic Development Representative I	12931	MS-16
Economic Development Representative II	12932	MS-21
Economic Development Representative Trainee	12939	MS-10
Educational Diagnostician	12965	MS-09
Educational Media Program Specialist	12980	MS-16
Educator	13100	MS-26
Educator – Provisional	13105	MS-10
Educator Aide	13130	MS-08
Educator Trainee	13148	MS-09
Electrical Engineer	13180	MS-28
Electroencephalograph Technician	13300	MS-05
Electronic Equipment Installer/Repairer	13340	MS-07
Electronic Equipment Installer/Repairer Lead Worker	13345	MS-09
Electronics Technician	13360	MS-12
Elevator Inspector	13495	MS-21
Elevator Operator	13500	MS-05
Emergency Response Lead Telecommunicator	13540	MS-10
Emergency Response Telecommunicator	13543	MS-08

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Employment Security Field Office Supervisor	13600	MS-23
Employment Security Manpower Representative I	13621	MS-09
Employment Security Manpower Representative II	13622	MS-11
Employment Security Program Representative	13650	MS-11
Employment Security Program Representative – Intermittent	13651	MS-11
Employment Security Service Representative	13667	MS-14
Employment Security Specialist I	13671	MS-11
Employment Security Specialist II	13672	MS-14
Employment Security Specialist III	13673	MS-21
Employment Security Tax Auditor I	13681	MS-16
Employment Security Tax Auditor II	13682	MS-21
End-User Computer Services Specialist I	13691	MS-24
End-User Computer Services Specialist II	13692	MS-28
End-User Computer Systems Analyst	13693	MS-30
Energy and Natural Resources Specialist I	13711	MS-12
Energy and Natural Resources Specialist II	13712	MS-16
Energy and Natural Resources Specialist III	13713	MS-21
Energy and Natural Resources Specialist Trainee	13715	MS-09
Engineering Technician I	13731	MS-10
Engineering Technician II	13732	MS-13
Engineering Technician III	13733	MS-20
Engineering Technician IV	13734	MS-30
Environmental Engineer I	13751	MS-12
Environmental Engineer II	13752	MS-16
Environmental Engineer III	13753	MS-21
Environmental Engineer IV	13754	MS-28
Environmental Equipment Operator I	13761	MS-09
Environmental Equipment Operator II	13762	MS-11
Environmental Health Specialist I	13768	MS-11
Environmental Health Specialist II	13769	MS-14
Environmental Health Specialist III	13770	MS-19
Environmental Protection Associate	13785	MS-09
Environmental Protection Engineer I	13791	MS-12
Environmental Protection Engineer II	13792	MS-16
Environmental Protection Engineer III	13793	MS-21
Environmental Protection Engineer IV	13794	MS-28
Environmental Protection Geologist I	13801	MS-12

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Environmental Protection Geologist II	13802	MS-16
Environmental Protection Geologist III	13803	MS-21
Environmental Protection Legal Investigator I	13811	MS-10
Environmental Protection Legal Investigator II	13812	MS-11
Environmental Protection Legal Investigator Specialist	13815	MS-13
Environmental Protection Specialist I	13821	MS-11
Environmental Protection Specialist II	13822	MS-14
Environmental Protection Specialist III	13823	MS-19
Environmental Protection Specialist IV	13824	MS-28
Environmental Protection Technician I	13831	MS-05
Environmental Protection Technician II	13832	MS-07
Equal Pay Specialist	13837	MS-16
Equine Investigator	13840	MS-09
Executive I	13851	MS-19
Executive II	13852	MS-23
Executive Secretary I	14031	MS-08
Executive Secretary II	14032	MS-11
Executive Secretary III	14033	MS-14
Explosives Inspector I	14051	MS-11
Explosives Inspector II	14052	MS-18
Facility Assistant Fire Chief	14430	MS-10
Facility Fire Chief	14433	MS-13
Facility Fire Safety Coordinator	14435	MS-09
Facility Firefighter	14439	MS-07
Ferry Operator I	14801	MS-18
Ferry Operator II	14802	MS-19
Financial Institutions Examiner I	14971	MS-14
Financial Institutions Examiner II	14972	MS-21
Financial Institutions Examiner III	14973	MS-28
Financial Institutions Examiner Trainee	14978	MS-10
Fingerprint Technician	15204	MS-10
Fingerprint Technician Supervisor	15208	MS-18
Fingerprint Technician Trainee	15209	MS-05
Fire Certification Specialist	15285	MS-16
Fire Prevention Inspector I	15316	MS-13
Fire Prevention Inspector II	15317	MS-20
Fire Prevention Inspector Trainee	15320	MS-10

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Fire Protection Specialist I	15351	MS-14
Flight Safety Coordinator	15640	MS-28
Florist II	15652	MS-08
Foreign Service Economic Development Executive I	15871	MS-32
Foreign Service Economic Development Executive II	15872	MS-34
Foreign Service Economic Development Representative	15875	MS-30
Forensic Science Administrator I	15911	MS-31
Forensic Science Administrator II	15912	MS-32
Forensic Scientist I	15891	MS-19
Forensic Scientist II	15892	MS-23
Forensic Scientist III	15893	MS-28
Forensic Scientist Trainee	15897	MS-12
Gaming Licensing Analyst	17171	MS-10
Gaming Senior Special Agent	17191	MS-29
Gaming Special Agent	17192	MS-21
Gaming Special Agent Trainee	17195	MS-11
Geographic Information Specialist I	17271	MS-21
Geographic Information Specialist II	17272	MS-29
Geographic Information Trainee	17276	MS-12
Governmental Career Trainee	17325	MS-09
Graduate Pharmacist	17345	MS-23
Graphic Arts Designer	17366	MS-11
Graphic Arts Designer Advanced	17370	MS-14
Graphic Arts Designer Supervisor	17365	MS-19
Graphic Arts Technician	17400	MS-09
Grounds Supervisor	17549	MS-18
Guard I	17681	MS-04
Guard II	17682	MS-06
Guard III	17683	MS-09
Guard Supervisor	17685	MS-11
Guardianship Representative	17710	MS-16
Guardianship Supervisor	17720	MS-24
Habilitation Program Coordinator	17960	MS-16
Handicapped Services Representative I	17981	MS-08
Health Facilities Surveillance Nurse	18150	MS-22
Health Facilities Surveyor I	18011	MS-14
Health Facilities Surveyor II	18012	MS-21

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Health Facilities Surveyor III	18013	MS-23
Health Information Associate	18045	MS-07
Health Information Technician	18047	MS-09
Health Services Investigator I, Option A – General	18181	MS-21
Health Services Investigator I, Option B – Controlled Substance Inspector	18182	MS-23
Health Services Investigator II, Option A – General	18185	MS-28
Health Services Investigator II, Option B – Controlled Substance Inspector	18186	MS-28
Health Services Investigator II, Option C – Pharmacy	18187	MS-32
Health Services Investigator II, Option D – Pharmacy/Controlled Substance Inspector	18188	MS-32
Hearing and Speech Advanced Specialist	18227	MS-28
Hearing and Speech Associate	18231	MS-19
Hearing and Speech Specialist	18233	MS-23
Hearing and Speech Technician I	18261	MS-04
Hearing and Speech Technician II	18262	MS-06
Hearings Referee	18300	MS-29
Hearings Referee – Intermittent	18301	MS-29
Heavy Construction Equipment Operator	18465	MS-18
Highway Construction Supervisor I	18525	MS-25
Highway Construction Supervisor II	18526	MS-30
Highway Maintainer	18639	MS-18
Highway Maintenance Lead Worker	18659	MS-18
Historical Documents Conservator I	18981	MS-10
Historical Exhibits Designer	18985	MS-12
Historical Library Chief Of Acquisitions	18987	MS-21
Historical Research Editor II	19002	MS-11
Historical Research Specialist	19008	MS-23
Housekeeper II	19602	MS-03
Human Relations Representative	19670	MS-14
Human Resources Assistant	19690	MS-05
Human Resources Associate	19691	MS-08
Human Resources Trainee	19694	MS-04
Human Rights Investigator I	19774	MS-14
Human Rights Investigator II	19775	MS-19
Human Rights Investigator III	19776	MS-21
Human Rights Mediation Supervisor	19769	MS-23

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Human Rights Mediator	19771	MS-16
Human Rights Specialist I	19778	MS-11
Human Rights Specialist II	19779	MS-14
Human Rights Specialist III	19780	MS-19
Human Services Casework Manager	19788	MS-23
Human Services Caseworker	19785	MS-14
Human Services Grants Coordinator I	19791	MS-11
Human Services Grants Coordinator II	19792	MS-16
Human Services Grants Coordinator III	19793	MS-23
Human Services Grants Coordinator Trainee	19796	MS-09
Human Services Sign Language Interpreter	19810	MS-14
Iconographer	19880	MS-09
Industrial and Community Development Representative I	21051	MS-16
Industrial and Community Development Representative II	21052	MS-21
Industrial Commission Reporter	21080	MS-14
Industrial Commission Technician	21095	MS-08
Industrial Services Consultant I	21121	MS-11
Industrial Services Consultant II	21122	MS-14
Industrial Services Consultant Trainee	21125	MS-08
Industrial Services Hygienist	21127	MS-21
Industrial Services Hygienist Technician	21130	MS-14
Industrial Services Hygienist Trainee	21133	MS-09
Information Services Intern	21160	MS-12
Information Services Specialist I	21161	MS-16
Information Services Specialist II	21162	MS-21
Information Systems Analyst I	21165	MS-25
Information Systems Analyst II	21166	MS-29
Information Systems Analyst III	21167	MS-32
Information Technology/Communications Systems Specialist I	21216	MS-21
Information Technology/Communications Systems Specialist II	21217	MS-31
Inhalation Therapist	21259	MS-05
Inhalation Therapy Supervisor	21260	MS-08
Institutional Helper	21460	MS-05
Institutional Maintenance Worker	21465	MS-05
Instrument Designer	21500	MS-19
Insurance Analyst I	21561	MS-06
Insurance Analyst II	21562	MS-09

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Insurance Analyst III	21563	MS-11
Insurance Analyst IV	21564	MS-14
Insurance Analyst Trainee	21566	MS-04
Insurance Company Claims Examiner I	21601	MS-16
Insurance Company Claims Examiner II	21602	MS-21
Insurance Company Field Staff Examiner	21608	MS-14
Insurance Company Financial Examiner Trainee	21610	MS-10
Insurance Performance Examiner I	21671	MS-11
Insurance Performance Examiner II	21672	MS-16
Insurance Performance Examiner III	21673	MS-23
Intermittent Clerk	21686	MS-02
Intermittent Laborer (Maintenance)	21687	MS-08
Intermittent Unemployment Insurance Representative	21689	MS-09
Intermittent Unemployment Insurance Technician	21690	MS-04
Internal Auditor I	21721	MS-16
Internal Auditor Trainee	21726	MS-09
Internal Security Investigator I	21731	MS-19
Internal Security Investigator II	21732	MS-25
International Marketing Representative I	21761	MS-11
Janitor I	21951	MS-13
Janitor II	21952	MS-14
Juvenile Justice Chief of Security	21965	MS-31
Juvenile Justice Specialist	21971	MS-20
Juvenile Justice Specialist Intern	21976	MS-13
Juvenile Justice Supervisor	21980	MS-27
Juvenile Justice Youth and Family Specialist Option 1	21991	MS-19
Juvenile Justice Youth and Family Specialist Option 2	21992	MS-23
Juvenile Justice Youth and Family Specialist Supervisor	21995	MS-28
Kidcare Supervisor	22003	MS-23
Labor Conciliator	22750	MS-23
Labor Maintenance Lead Worker	22809	MS-16
Laboratory Assistant	22995	MS-03
Laboratory Associate I	22997	MS-07
Laboratory Associate II	22998	MS-09
Laboratory Equipment Specialist	22990	MS-19
Laboratory Quality Specialist I	23021	MS-21
Laboratory Quality Specialist II	23022	MS-25

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Laboratory Research Scientist	23025	MS-29
Laboratory Research Specialist I	23027	MS-21
Laboratory Research Specialist II	23028	MS-25
Laborer (Maintenance)	23080	MS-15
Land Acquisition Agent I	23091	MS-12
Land Acquisition Agent II	23092	MS-19
Land Acquisition Agent III	23093	MS-25
Land Reclamation Specialist I	23131	MS-11
Land Reclamation Specialist II	23132	MS-16
Landscape Architect	23145	MS-28
Landscape Planner	23150	MS-21
Laundry Manager I	23191	MS-10
Legal Research Assistant	23350	MS-10
Liability Claims Adjuster I	23371	MS-11
Liability Claims Adjuster II	23372	MS-19
Liability Claims Adjuster Trainee	23375	MS-09
Librarian I	23401	MS-14
Librarian II	23402	MS-19
Library Aide I	23421	MS-03
Library Aide II	23422	MS-04
Library Aide III	23423	MS-05
Library Associate	23430	MS-09
Library Technical Assistant	23450	MS-07
Licensed Practical Nurse I	23551	MS-09
Licensed Practical Nurse II	23552	MS-10
Licensing Assistant	23568	MS-05
Licensing Investigator I	23571	MS-10
Licensing Investigator II	23572	MS-13
Licensing Investigator III	23573	MS-15
Licensing Investigator IV	23574	MS-20
Life Sciences Career Trainee	23600	MS-09
Liquor Control Special Agent I	23751	MS-13
Liquor Control Special Agent II	23752	MS-14
Local Historical Services Representative	24000	MS-16
Local Housing Advisor I	24031	MS-11
Local Housing Advisor II	24032	MS-14
Local Housing Advisor III	24033	MS-19

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Local Revenue and Fiscal Advisor I	24101	MS-12
Local Revenue and Fiscal Advisor II	24102	MS-16
Local Revenue and Fiscal Advisor III	24103	MS-21
Lock and Dam Tender	24290	MS-07
Locksmith	24300	MS-16
Lottery Commodities Distributor II	24402	MS-09
Lottery Regional Coordinator	24504	MS-21
Lottery Sales Representative	24515	MS-14
Lottery Telemarketing Representative	24520	MS-06
Maintenance Equipment Operator	25020	MS-18
Maintenance Worker	25500	MS-16
Management Operations Analyst I	25541	MS-19
Management Operations Analyst II	25542	MS-23
Management Operations Analyst Trainee	25545	MS-12
Management Systems Specialist	25583	MS-25
Manpower Planner I	25591	MS-11
Manpower Planner II	25592	MS-16
Manpower Planner III	25593	MS-23
Manpower Planner Trainee	25597	MS-09
Manuscripts Manager	25610	MS-21
Meat and Poultry Inspector	26070	MS-10
Meat and Poultry Inspector Supervisor	26073	MS-13
Meat and Poultry Inspector Trainee	26075	MS-07
Mechanical Engineer I	26201	MS-12
Mechanical Engineer II	26202	MS-16
Mechanical Engineer III	26203	MS-21
Medical Administrator I Option C	26400	MS-60
Medical Administrator I Option D	26401	MS-62
Medical Administrator II Option C	26402	MS-61
Medical Administrator II Option D	26403	MS-64
Medical Administrator III	26404	MS-65
Medical Administrator IV	26405	MS-66
Medical Administrator V	26406	MS-67
Medical Assistance Consultant I	26501	MS-10
Medical Assistance Consultant II	26502	MS-14
Medical Assistance Consultant III	26503	MS-21
Mental Health Administrator I	26811	MS-19

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Mental Health Administrator II	26812	MS-23
Mental Health Administrator Trainee	26817	MS-14
Mental Health Program Administrator	26908	MS-63
Mental Health Recovery Support Specialist I	26921	MS-16
Mental Health Recovery Support Specialist II	26922	MS-19
Mental Health Specialist I	26924	MS-09
Mental Health Specialist II	26925	MS-11
Mental Health Specialist III	26926	MS-14
Mental Health Specialist Trainee	26928	MS-08
Mental Health Technician I	27011	MS-04
Mental Health Technician II	27012	MS-05
Mental Health Technician III	27013	MS-06
Mental Health Technician IV	27014	MS-07
Mental Health Technician V	27015	MS-08
Mental Health Technician VI	27016	MS-09
Mental Health Technician Trainee	27020	MS-03
Meteorologist	27120	MS-19
Methods and Procedures Advisor I	27131	MS-11
Methods and Procedures Advisor II	27132	MS-14
Methods and Procedures Advisor III	27133	MS-23
Methods and Procedures Career Associate I	27135	MS-08
Methods and Procedures Career Associate II	27136	MS-09
Methods and Procedures Career Associate Trainee	27137	MS-06
Metrologist Associate	27146	MS-12
Microbiologist I	27151	MS-14
Microbiologist II	27152	MS-21
Microfilm Laboratory Technician I	27175	MS-04
Microfilm Laboratory Technician II	27176	MS-06
Microfilm Operator I	27181	MS-03
Microfilm Operator II	27182	MS-04
Microfilm Operator III	27183	MS-05
Mine Rescue Station Assistant	28150	MS-07
Motorist Assistance Specialist	28490	MS-05
Musician	28805	MS-05
Natural Resource Technician I	28851	MS-07
Natural Resource Technician II	28852	MS-10
Natural Resources Advanced Specialist	28833	MS-23

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Natural Resources Coordinator	28831	MS-12
Natural Resources Education Program Coordinator	28834	MS-23
Natural Resources Grant Coordinator	28835	MS-20
Natural Resources Manager I	28836	MS-23
Natural Resources Manager II	28837	MS-26
Natural Resources Manager III	28838	MS-30
Natural Resources Site Manager I	28841	MS-23
Natural Resources Site Manager II	28842	MS-26
Natural Resources Specialist	28832	MS-19
Nursing Act Assistant Coordinator	29731	MS-25
Nutritionist	29820	MS-19
Occupational Therapist	29900	MS-16
Occupational Therapist Program Coordinator	29908	MS-21
Occupational Therapist Supervisor	29910	MS-25
Office Administrative Specialist	29990	MS-09
Office Administrator I	29991	MS-04
Office Administrator II	29992	MS-06
Office Administrator III	29993	MS-08
Office Administrator IV	29994	MS-11
Office Administrator V	29995	MS-12
Office Aide	30005	MS-02
Office Assistant	30010	MS-04
Office Associate	30015	MS-05
Office Clerk	30020	MS-03
Office Coordinator	30025	MS-06
Office Occupations Trainee	30075	MS-01
Office Specialist	30080	MS-08
Optometrist	30300	MS-11
Oral Health Consultant	30317	MS-19
Paralegal Assistant	30860	MS-11
Pension and Death Benefits Technician I	30961	MS-09
Pension and Death Benefits Technician II	30962	MS-21
Pest Control Operator	31810	MS-07
Pharmacy Lead Technician	32009	MS-06
Pharmacy Services Coordinator	32010	MS-32
Pharmacy Technician	32011	MS-04
<u>Photographer</u>	<u>32080</u>	<u>MS-11</u>

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<del>Photographer I</del>	<del>32085</del>	<del>MS-08</del>
<del>Photographer II</del>	<del>32086</del>	<del>MS-11</del>
<del>Photographer III</del>	<del>32087</del>	<del>MS-12</del>
Photographic Technician I	32091	MS-08
Photographic Technician II	32092	MS-11
Photographic Technician III	32093	MS-12
Physical Therapist	32145	MS-16
Physical Therapist Program Coordinator	32153	MS-21
Physical Therapy Aide I	32191	MS-03
Physical Therapy Aide II	32192	MS-05
Physical Therapy Aide III	32193	MS-08
Physician	32200	MS-36
Physician Assistant	32210	MS-27
Physician Specialist – Option A	32221	MS-37
Physician Specialist – Option B	32222	MS-38
Physician Specialist – Option C	32223	MS-61
Physician Specialist – Option D	32224	MS-63
Physician Specialist – Option E	32225	MS-65
Plant and Pesticide Specialist I	32501	MS-15
Plant and Pesticide Specialist II	32502	MS-20
Plant and Pesticide Specialist Supervisor	32506	MS-20
Plumbing Consultant	32910	MS-28
Plumbing Inspector	32915	MS-22
Podiatrist	32960	MS-11
Police Lieutenant	32977	MS-31
Police Officer I	32981	MS-15
Police Officer II	32982	MS-20
Police Officer III	32983	MS-24
Police Officer Trainee	32985	MS-06
Police Training Specialist	32990	MS-16
Polygraph Examiner I	33001	MS-20
Polygraph Examiner II	33002	MS-24
Polygraph Examiner III	33003	MS-28
Polygraph Examiner Trainee	33005	MS-12
Power Shovel Operator	33360	MS-18
Private Secretary I	34201	MS-13
Private Secretary II	34202	MS-18

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Procurement Representative	34540	MS-06
Products and Standards Inspector	34603	MS-11
Products and Standards Inspector Trainee	34605	MS-09
Program Integrity Auditor I	34631	MS-14
Program Integrity Auditor II	34632	MS-21
Program Integrity Auditor Trainee	34635	MS-09
Project Designer	34725	MS-21
Property and Supply Clerk I	34791	MS-03
Property and Supply Clerk II	34792	MS-04
Property and Supply Clerk III	34793	MS-05
Property Consultant	34900	MS-12
Psychologist Associate	35626	MS-12
Psychologist I	35611	MS-16
Psychologist II	35612	MS-23
Psychologist III	35613	MS-28
Psychology Intern	35660	MS-15
Public Administration Intern	35700	MS-11
Public Aid Eligibility Assistant	35825	MS-05
Public Aid Investigator	35870	MS-21
Public Aid Investigator Trainee	35874	MS-11
Public Aid Lead Casework Specialist	35880	MS-16
Public Aid Program Quality Analyst	35890	MS-21
Public Aid Quality Control Reviewer	35892	MS-16
Public Aid Quality Control Supervisor	35900	MS-21
Public Aid Staff Development Specialist I	36071	MS-12
Public Aid Staff Development Specialist II	36072	MS-16
Public Aid Staff Development Specialist III	36073	MS-22
Public Health Educator	36430	MS-21
Public Health Educator Associate	36434	MS-11
Public Health Program Specialist I	36611	MS-11
Public Health Program Specialist II	36612	MS-14
Public Health Program Specialist III	36613	MS-21
Public Health Program Specialist Trainee	36615	MS-09
Public Information Coordinator	36750	MS-19
Public Information Officer I	37001	MS-09
Public Information Officer II	37002	MS-11
Public Information Officer III	37003	MS-21

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Public Information Officer IV	37004	MS-25
Public Safety Inspector	37007	MS-14
Public Safety Inspector Trainee	37010	MS-07
Public Service Trainee	37025	MS-01
Race Track Maintainer I	37551	MS-10
Race Track Maintainer II	37552	MS-12
Radiologic Technologist	37500	MS-08
Radiologic Technologist Chief	37505	MS-17
Radiologic Technologist Program Coordinator	37507	MS-09
Railroad Safety Specialist I	37601	MS-21
Railroad Safety Specialist II	37602	MS-25
Railroad Safety Specialist III	37603	MS-29
Railroad Safety Specialist IV	37604	MS-32
Ranger	37725	MS-10
Real Estate Investigator	37730	MS-21
Real Estate Professions Examiner	37760	MS-28
Recreation Worker I	38001	MS-09
Recreation Worker II	38002	MS-11
Refrigeration and Air Conditioning Repairer	38119	MS-12
Registered Nurse – Advanced Practice	38135	MS-26
Registered Nurse I	38131	MS-18
Registered Nurse II	38132	MS-22
Rehabilitation Case Coordinator I	38141	MS-05
Rehabilitation Case Coordinator II	38142	MS-07
Rehabilitation Counselor	38145	MS-16
Rehabilitation Counselor Aide I	38155	MS-06
Rehabilitation Counselor Aide II	38156	MS-08
Rehabilitation Counselor Senior	38158	MS-21
Rehabilitation Counselor Trainee	38159	MS-12
Rehabilitation Services Advisor I	38176	MS-23
Rehabilitation Workshop Instructor I	38192	MS-05
Rehabilitation Workshop Instructor II	38193	MS-09
Rehabilitation Workshop Supervisor I	38194	MS-09
Rehabilitation Workshop Supervisor II	38195	MS-11
Rehabilitation Workshop Supervisor III	38196	MS-14
Rehabilitation/Mobility Instructor	38163	MS-21
Rehabilitation/Mobility Instructor Trainee	38167	MS-12

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Reimbursement Officer I	38199	MS-11
Reimbursement Officer II	38200	MS-14
Reproduction Service Supervisor I	38201	MS-10
Reproduction Service Supervisor II	38202	MS-18
Reproduction Service Technician I	38203	MS-03
Reproduction Service Technician II	38204	MS-06
Reproduction Service Technician III	38205	MS-08
Research Economist I	38207	MS-19
Research Fellow, Option B	38211	MS-19
Research Scientist I	38231	MS-10
Research Scientist II	38232	MS-14
Research Scientist III	38233	MS-23
Resident Physician	38270	MS-15
Residential Care Program Supervisor I	38271	MS-22
Residential Care Worker	38277	MS-09
Residential Care Worker Trainee	38279	MS-05
Resource Planner I	38281	MS-16
Resource Planner II	38282	MS-21
Resource Planner III	38283	MS-28
Retirement System Disability Specialist	38310	MS-21
Revenue Audit Supervisor	38369	MS-32
Revenue Auditor I	38371	MS-14
Revenue Auditor II	38372	MS-21
Revenue Auditor III	38373	MS-28
Revenue Auditor Trainee	38375	MS-09
Revenue Collection Officer I	38401	MS-12
Revenue Collection Officer II	38402	MS-16
Revenue Collection Officer III	38403	MS-21
Revenue Collection Officer Trainee	38405	MS-09
Revenue Computer Audit Specialist	38425	MS-29
Revenue Senior Special Agent	38557	MS-29
Revenue Special Agent	38558	MS-21
Revenue Special Agent Trainee	38565	MS-11
Revenue Tax Specialist I	38571	MS-09
Revenue Tax Specialist II	38572	MS-11
Revenue Tax Specialist III	38573	MS-16
Revenue Tax Specialist Trainee	38575	MS-07

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Safety Responsibility Analyst	38910	MS-09
Safety Responsibility Analyst Supervisor	38915	MS-11
School Psychologist	39200	MS-21
Security Guard I	39851	MS-13
Security Guard II	39852	MS-14
Security Officer	39870	MS-10
Security Officer Chief	39875	MS-13
Security Officer Lieutenant	39876	MS-11
Security Officer Sergeant	39877	MS-10
Security Therapy Aide I	39901	MS-10
Security Therapy Aide II	39902	MS-11
Security Therapy Aide III	39903	MS-13
Security Therapy Aide IV	39904	MS-16
Security Therapy Aide Trainee	39905	MS-06
Seed Analyst I	39951	MS-09
Seed Analyst II	39952	MS-10
Seed Analyst Trainee	39953	MS-07
Senior Ranger	40090	MS-11
<u>Sex Offender Therapist I</u>	<u>40531</u>	<u>MS-16</u>
<u>Sex Offender Therapist II</u>	<u>40532</u>	<u>MS-21</u>
Shift Supervisor	40800	MS-31
Sign Shop Foreman	41000	MS-12
Silk Screen Operator	41020	MS-17
Site Assistant Superintendent I	41071	MS-12
Site Assistant Superintendent II	41072	MS-16
Site Interpreter	41090	MS-07
Site Interpretive Coordinator	41093	MS-10
Site Security Officer	41115	MS-06
Site Services Specialist I	41117	MS-12
Site Services Specialist II	41118	MS-16
Site Superintendent I	41211	MS-20
Site Superintendent II	41212	MS-25
Site Superintendent III	41213	MS-29
Site Technician I	41131	MS-07
Site Technician II	41132	MS-09
Small Engine Mechanic	41150	MS-10
Social Service Aide I	41281	MS-05

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Social Service Aide II	41282	MS-08
Social Service Aide Trainee	41285	MS-03
Social Service Community Planner	41295	MS-08
Social Service Consultant I	41301	MS-19
Social Service Consultant II	41302	MS-21
Social Service Program Planner I	41311	MS-12
Social Service Program Planner II	41312	MS-16
Social Service Program Planner III	41313	MS-23
Social Service Program Planner IV	41314	MS-28
Social Services Career Trainee	41320	MS-09
Social Worker I	41411	MS-16
Social Worker II	41412	MS-21
Social Worker III	41413	MS-23
Social Worker IV	41414	MS-28
Social Worker Intern	41430	MS-15
Staff Development Specialist I	41771	MS-19
Staff Development Technician I	41781	MS-09
Staff Development Technician II	41782	MS-12
Staff Pharmacist	41787	MS-31
State Mine Inspector	42230	MS-21
State Mine Inspector-At-Large	42240	MS-31
State Police Crime Information Evaluator	41801	MS-08
State Police Evidence Technician I	41901	MS-09
State Police Evidence Technician II	41902	MS-10
State Police Field Specialist I	42001	MS-19
State Police Field Specialist II	42002	MS-23
Statistical Research Specialist I	42741	MS-09
Statistical Research Specialist II	42742	MS-11
Statistical Research Specialist III	42743	MS-16
Statistical Research Supervisor	42745	MS-23
Statistical Research Technician	42748	MS-08
Storage Tank Safety Specialist	43005	MS-19
Storekeeper I	43051	MS-11
Storekeeper II	43052	MS-12
Storekeeper III	43053	MS-13
Stores Clerk	43060	MS-03
Student Intern	43190	MS-01

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Student Worker	43200	MS-01
Supervising Vehicle Testing Compliance Officer	43680	MS-22
Support Service Coordinator I	44221	MS-07
Support Service Coordinator II	44222	MS-09
Support Service Lead	44225	MS-04
Support Service Worker	44238	MS-03
Switchboard Chief Operator	44410	MS-11
Switchboard Operator I	44411	MS-03
Switchboard Operator II	44412	MS-04
Switchboard Operator III	44413	MS-06
Technical Advisor Advanced Program Specialist	45256	MS-31
Technical Advisor I	45251	MS-19
Technical Advisor II	45252	MS-23
Technical Advisor III	45253	MS-29
Technical Manager I	45261	MS-18
Telecommunications Specialist	45295	MS-12
Telecommunications Supervisor	45305	MS-23
Telecommunications Systems Analyst	45308	MS-16
Telecommunications Systems Technician I	45312	MS-07
Telecommunications Systems Technician II	45313	MS-10
Telecommunications Systems Technician Trainee	45314	MS-05
Telecommunicator	45321	MS-09
Telecommunicator – Command Center	45316	MS-10
Telecommunicator Call Taker	45322	MS-11
Telecommunicator Lead Call Taker	45323	MS-14
Telecommunicator Lead Specialist	45327	MS-16
Telecommunicator Lead Worker	45324	MS-11
Telecommunicator Lead Worker – Command Center	45318	MS-12
Telecommunicator Specialist	45326	MS-12
Telecommunicator Trainee	45325	MS-07
Terrorism Research Specialist I	45371	MS-19
Terrorism Research Specialist II	45372	MS-23
Terrorism Research Specialist III	45373	MS-28
Terrorism Research Specialist Trainee	45375	MS-11
Transportation Officer	45830	MS-11
Truck Weighing Inspector	46100	MS-10
Unemployment Insurance Adjudicator I	47001	MS-08

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Unemployment Insurance Adjudicator II	47002	MS-10
Unemployment Insurance Adjudicator III	47003	MS-12
Unemployment Insurance Revenue Analyst I	47081	MS-12
Unemployment Insurance Revenue Analyst II	47082	MS-16
Unemployment Insurance Revenue Specialist	47087	MS-10
Unemployment Insurance Special Agent	47096	MS-19
Utility Engineer I	47451	MS-20
Utility Engineer II	47452	MS-24
Vehicle Compliance Inspector	47570	MS-15
Vehicle Emission Compliance Inspector	47580	MS-10
Vehicle Emission Compliance Supervisor	47583	MS-12
Vehicle Emission Quality Assurance Auditor	47584	MS-10
Vehicle Permit Evaluator	47585	MS-08
Veterans Educational Specialist I	47681	MS-12
Veterans Educational Specialist II	47682	MS-16
Veterans Educational Specialist III	47683	MS-25
Veterans Employment Representative I	47701	MS-11
Veterans Employment Representative II	47702	MS-14
Veterans Nursing Assistant – Certified	47750	MS-05
Veterans Service Officer	47800	MS-11
Veterans Service Officer Associate	47804	MS-10
Veterinarian I	47901	MS-19
Veterinarian II	47902	MS-23
Veterinarian III	47903	MS-25
Veterinary Consumer Safety Officer	47911	MS-20
Veterinary Pathologist	47916	MS-29
Veterinary Supervisor I	47917	MS-25
Veterinary Supervisor II	47918	MS-26
Vision/Hearing Consultant I	47941	MS-14
Vision/Hearing Consultant II	47942	MS-23
Vision/Hearing Consultant III	47943	MS-25
Vital Records Quality Control Inspector	48000	MS-10
Vocational Instructor	48200	MS-09
Volunteer Services Coordinator I	48481	MS-10
Volunteer Services Coordinator II	48482	MS-14
Volunteer Services Coordinator III	48483	MS-19
Wage Claims Specialist	48770	MS-06

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Warehouse Claims Specialist	48780	MS-22
Warehouse Examiner	48881	MS-13
Warehouse Examiner Specialist	48882	MS-18
Warehouse Examiner Supervisor	48786	MS-20
Waterways Construction Supervisor I	49061	MS-14
Waterways Construction Supervisor II	49062	MS-19
Weatherization Specialist I	49101	MS-11
Weatherization Specialist II	49102	MS-16
Weatherization Specialist III	49103	MS-23
Weatherization Specialist Trainee	49105	MS-09
Well Inspector I	49421	MS-11
Well Inspector II	49422	MS-18
Workers Compensation Insurance Compliance Investigator	49640	MS-23

NOTE: Effective January 1, 2008, the merit compensation grade 12 in the Personnel Code [20 ILCS 415/8b.18(a) and (b) and 8b.19(a) and (b)] that formerly was indicated by MC-12 is MS-32.

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

**Section 310.500 Definitions**

The following are definitions of certain terms and are for purposes of clarification as they affect the Merit Compensation System only.

"Adjustment in Salary" – A change in salary occasioned by previously committed error or oversight, or required in the best interest of the agency or the state as defined in Sections 310.470 and 310.480.

"Base Salary" – The dollar amount of pay of an employee as determined under the provisions of the Merit Compensation System. Base salary does not include commission, incentive pay, bilingual pay, longevity pay, overtime pay, shift differential pay or deductions for time not worked.

"Bilingual Pay" – The dollar amount per month, or percentage of the employee's monthly base salary, paid in addition to the employee's base salary when the individual position held by the employee has a job description that requires the use of sign language, Braille, or another second language (e.g., Spanish), or that requires the employee to be bilingual.

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"Classification" – The classification established based on the Personnel Code [20 ILCS 415/8a(1)] and to which one or more positions are allocated based upon similarity of duties performed, responsibilities assigned and conditions of employment. Classification may be abbreviated to "class" and referred to by its title or title code.

"Class Specification" – The document comprising the title, title code, effective date, distinguishing features of work, illustrative examples of work and desirable requirements.

"Creditable Service" – All service in full or regularly scheduled part-time pay status beginning with the date of initial employment or the effective date of the last in-range or promotional salary increase. Reevaluations (Sections 310.460(c) and 310.480(d)), reallocations (Sections 310.460(b) and 310.480(b)), adjustments (Sections 310.470, 310.480(e) and 310.495(c)) and interim assignments (Section 310.490(p)) shall not change the creditable service date.

"Comparable Classes" – Two or more classes that are in the same salary range.

"Demotion" – The assignment for cause of an employee to a vacant position in a class in a lower salary range than the former class.

"Differential" – The additional compensation added to the base salary of an employee resulting from conditions of employment imposed during the normal schedule of work.

"Entrance Base Salary" – The initial base salary assigned to an employee upon entering State service.

"Maximum Rate of Pay" – The highest rate of pay for a given salary range.

"Minimum Rate of Pay" – The lowest rate of pay for a given salary range. Normally the minimum rate of pay represents the salary to be paid a qualified employee who is appointed to a position in a class assigned to a given salary range.

"Option" – The denotation of directly-related education, experience and/or knowledge, skills and abilities required to qualify for the position allocated to the

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classification. The requirements may meet or exceed the requirements indicated in the classification specification. The following options are for the Public Service Administrator classification and have a negotiated pay grade and/or a broad-banded salary range assigned:

1	=	General Administration/Business Marketing/Labor/Personnel
2	=	Fiscal Management/Accounting/Budget/Internal Audit/Insurance/Financial
2B	=	Financial Regulatory
2C	=	Economist
3	=	Management Information System/Data Processing/ Telecommunications
3J	=	Java Application Developer
3N	=	Wide Area Networks
4	=	Physical Sciences/Environment
6	=	Health and Human Services
6B	=	Day Care Quality Assurance
6C	=	Health Statistics
6D	=	Health Promotion/Disease Prevention
6E	=	Laboratory Specialist
6F	=	Infectious Disease
6G	=	Disaster/Emergency Medical Services
7	=	Law Enforcement/Correctional
8A	=	Special License – Architect License
8B	=	Special License – Boiler Inspector License
8C	=	Special License – Certified Public Accountant
8D	=	Special License – Federal Communications Commission License/National Association of Business and Educational Radio
8E	=	Special License – Engineer (Professional)
8F	=	Special License – Federal Aviation Administration Medical Certificate/First Class
8G	=	Special License – Clinical Professional Counselor
8H	=	Special License – Environmental Health Practitioner
8I	=	Special License – Professional Land Surveyor License
8J	=	Special License – Registered American Dietetic Association/Public Health Food Service Sanitation Certificate/Licensed Dietitian

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8K	=	Special License – Licensed Psychologist
8L	=	Special License – Law License
8N	=	Special License – Registered Nurse License
8O	=	Special License – Occupational Therapist License
8P	=	Special License – Pharmacist License
8Q	=	Special License – Religious Ordination by Recognized Commission
8R	=	Special License – Dental Hygienist
8S	=	Special License – Social Worker/Clinical Social Worker
8T	=	Special License – Administrative Certificate issued by the Illinois State Board of Education
8U	=	Special License – Physical Therapist License
8V	=	Special License – Audiologist License
8W	=	Special License – Speech-Language Pathologist License
8X	=	Special License – Blaster Certificate
8Y	=	Special License – Plumbing License
8Z	=	Special License – Special Metrologist Training
9A	=	Special License – Certified Internal Auditor
9B	=	Special License – Certified Information Systems Auditor
9G	=	Special License – Registered Professional Geologist License

The following options are for the Senior Public Service Administrator classification and have a negotiated pay grade and/or a broad-banded salary range assigned:

1	=	General Administration/Business Marketing/Labor/Personnel
2	=	Fiscal Management/Accounting/Budget/ Internal Audit/Insurance/Financial
2B	=	Financial Regulatory
3	=	Management Information System/Data Processing/Telecommunications
4	=	Physical Sciences/Environment
5	=	Agriculture/Conservation
6	=	Health and Human Services
7	=	Law Enforcement/Correctional
8A	=	Special License – Architect License

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8B	=	Special License – Boiler Inspector License
8C	=	Special License – Certified Public Accountant/Certified Internal Auditor/Certified Information Systems Auditor
8D	=	Special License – Dental License
8E	=	Special License – Engineer (Professional)
8F	=	Special License – Clinical Professional Counseling
8G	=	Special License – Geologist License
8H	=	Special License – Environmental Health Practitioner
8I	=	Special License – Illinois Auctioneer License
8K	=	Special License – Licensed Psychologist
8L	=	Special License – Law License (Illinois)
8M	=	Special License – Veterinary Medicine License
8N	=	Special License – Nurse (Registered IL) License
8O	=	Special License – Occupational Therapist License
8P	=	Special License – Pharmacist License
8Q	=	Special License – Nursing Home Administration License
8R	=	Special License – Real Estate Brokers License
8S	=	Special License – Social Worker/Clinical Social Worker
8T	=	Special License – Illinois Teaching Certificate (Type 75)/General Administrative Certificate (Type 61) issued by the Illinois State Board of Education
8Z	=	Special License – Certified Real Estate Appraisal License

Other classification titles contain an option and the option also may denote differences in the distinguishing features of work indicated in the classification specification. The classification titles containing an option are:

Children and Family Service Intern, Option 1  
Children and Family Service Intern, Option 2  
Health Services Investigator I, Option A – General  
Health Services Investigator I, Option B – Controlled Substance Inspector  
Health Services Investigator II, Option A – General  
Health Services Investigator II, Option B – Controlled Substance Inspector  
Health Services Investigator II, Option C – Pharmacy  
Health Services Investigator II, Option D – Pharmacy/Controlled Substance Inspector

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Juvenile Justice Youth and Family Specialist Option 1  
Juvenile Justice Youth and Family Specialist Option 2  
Medical Administrator I Option C  
Medical Administrator I Option D  
Medical Administrator II Option C  
Medical Administrator II Option D  
Physician Specialist – Option A  
Physician Specialist – Option B  
Physician Specialist – Option C  
Physician Specialist – Option D  
Physician Specialist – Option E  
Research Fellow, Option B

"Performance Review" – The required review of an employee's on-the-job performance as measured by a specific set of criteria.

"Performance Review Date" – The date on which the annual merit increase and bonus shall be made effective if a performance review indicates it is appropriate. Actual performance review procedures are to be completed prior to the effective date of any recommendation to allow sufficient time for the records to be processed by the originating agency.

"Promotion" – The appointment of an employee, with the approval of the agency and the Department of Central Management Services, to a vacant position in a class in a higher salary range than the former class.

"Reallocation" – The change in the classification of a position resulting from significant changes in assigned duties and responsibilities.

"Reclassification" – The assignment of a position or positions to a different classification based on creation of a new classification or the revision of existing class specification, and approved by the Civil Service Commission.

"Reevaluation" – The assignment of a different salary range to a class of positions based upon a change in relation to other classes or to the labor market.

"Salary Range" – The dollar values encompassed by the minimum and maximum rates of pay of a salary range assigned to a class title.

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"Transfer" – The assignment of an employee to a vacant position in a class having the same salary range.

"Work Year" – That period of time determined by the agency and filed with the Department of Central Management Services in accordance with 80 Ill. Adm. Code 303.300.

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

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**Section 310.APPENDIX A Negotiated Rates of Pay****Section 310.TABLE A RC-104 (Conservation Police Supervisors, Laborers' – ISEA Local #2002)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Plan Code</u>
Conservation Police Sergeant	09347	RC-104	Q
Conservation Police Lieutenant	<del>09339</del> 09340	RC-104	Q
Senior Public Service Administrator, Option 7 (captain function) Department of Natural Resources	40070	RC-104	Q

NOTE: The positions allocated to the Senior Public Service Administrator title that are assigned to the negotiated RC-104 rates have the Option 7. See the definition of option in Section 310.50.

**Effective July 1, 2011**

<u>Title</u>	<u>STEPS</u>						
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>
Conservation Police Sergeant	5260	5531	5798	6067	6350	6646	6646
Conservation Police Lieutenant	5417	5694	5968	6247	6536	6842	6842
Senior Public Service Administrator, Option 7 (captain function) Department of Natural Resources	5688	5980	6268	6559	6862	7183	7183

**Longevity Bonus Rates**

<u>Title</u>	<u>9 Yrs</u>	<u>10 Yrs</u>	<u>12.5 Yrs</u>	<u>14 Yrs</u>	<u>15 Yrs</u>	<u>17.5 Yrs</u>	<u>20 Yrs</u>	<u>21 Yrs</u>	<u>22.5 Yrs</u>	<u>25 Yrs</u>
Conservation Police Sergeant	6956	7357	7539	7539	7893	8263	8664	8745	9155	9587
Conservation Police Lieutenant	7160	7574	7758	7758	8125	8507	8916	9000	9423	9869

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Senior Public Service Administrator, Option 7 (captain function) Department of Natural Resources	7517	7954	8146	8146	8531	8931	9363	9450	9895	10363
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**Effective January 1, 2012**

Title	S T E P S						
	1	2	3	4	5	6	7
Conservation Police Sergeant	5353	5628	5899	6174	6461	6763	6763
Conservation Police Lieutenant	5512	5794	6073	6357	6651	6963	6963
Senior Public Service Administrator, Option 7 (captain function) Department of Natural Resources	5788	6085	6378	6674	6983	7309	7309

**Longevity Bonus Rates**

Title	9 Yrs	10 Yrs	12.5 Yrs	14 Yrs	15 Yrs	17.5 Yrs	20 Yrs	21 Yrs	22.5 Yrs	25 Yrs
Conservation Police Sergeant	7078	7486	7671	7671	8032	8408	8816	8898	9315	9756
Conservation Police Lieutenant	7286	7707	7894	7894	8268	8656	9072	9159	9589	10042
Senior Public Service Administrator, Option 7 (captain function) Department of Natural Resources	7649	8093	8289	8289	8681	9088	9527	9616	10069	10545

**Effective June 30, 2012**

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Title	S T E P S						
	1	2	3	4	5	6	7
Conservation Police Sergeant	5380	5656	5928	6205	6493	6797	6797
Conservation Police Lieutenant	5540	5823	6103	6389	6684	6998	6998
Senior Public Service Administrator, Option 7 (captain function) Department of Natural Resources	5817	6115	6410	6707	7018	7346	7346

## Longevity Bonus Rates

Title	9 Yrs	10 Yrs	12.5 Yrs	14 Yrs	15 Yrs	17.5 Yrs	20 Yrs	21 Yrs	22.5 Yrs	25 Yrs
Conservation Police Sergeant	7113	7523	7709	7709	8072	8450	8860	8942	9362	9805
Conservation Police Lieutenant	7322	7746	7933	7933	8309	8699	9117	9205	9637	10092
Senior Public Service Administrator, Option 7 (captain function) Department of Natural Resources	7687	8133	8330	8330	8724	9133	9575	9664	10119	10598

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

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## NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX A Negotiated Rates of Pay****Section 310.TABLE G RC-045 (Automotive Mechanics, IFPE)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Plan Code</u>	<u>September 10, 2010 Monthly Rate</u>	<u>January 1, 2011 Monthly Rate</u>
<u>Automotive</u>					
<u>Mechanic (Hired on or after September 1, 2010)</u>	<u>03700</u>	<u>RC-045</u>	<u>B</u>	<u>4692</u>	<u>4786</u>
<u>Automotive</u>					
<u>Mechanic (Hired on or after September 1, 2010)</u>	<u>03700</u>	<u>RC-045</u>	<u>Q</u>	<u>4858</u>	<u>4955</u>
<u>Automotive</u>					
<u>Mechanic (Hired on or after September 1, 2010)</u>	<u>03700</u>	<u>RC-045</u>	<u>S</u>	<u>4927</u>	<u>5026</u>

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Plan Code</u>	<u>July 1, 2011 Monthly Rate</u>	<u>January 1, 2012 Monthly Rate</u>
Auto & Body Repairer (See Note)	03680	RC-045	B	5352	5432
Auto & Body Repairer (See Note)	03680	RC-045	Q	5541	5624
Auto & Body Repairer (See Note)	03680	RC-045	S	5620	5704
Automotive Attendant I (See Note)	03696	RC-045	B	3233	3281
Automotive Attendant I (See Note)	03696	RC-045	Q	3361	3411
Automotive Attendant I (See Note)	03696	RC-045	S	3433	3484
Automotive Attendant II (See Note)	03697	RC-045	B	3452	3504
Automotive Attendant II (See Note)	03697	RC-045	Q	3588	3642
Automotive Attendant II (See Note)	03697	RC-045	S	3659	3714
<u>Automotive Mechanic</u>	<u>03700</u>	<u>RC-045</u>	<u>B</u>	<u>4977</u>	<u>5052</u>

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<u>(Hired on or after September 1, 2010)</u> <u>Automotive Mechanic</u> <u>(Hired on or after September 1, 2010)</u>	<u>03700</u>	<u>RC-045</u>	<u>Q</u>	<u>5153</u>	<u>5230</u>
<u>Automotive Mechanic</u> <u>(Hired on or after September 1, 2010)</u>	<u>03700</u>	<u>RC-045</u>	<u>S</u>	<u>5227</u>	<u>5305</u>
Automotive Mechanic (See Note)	03700	RC-045	B	5352	5432
Automotive Mechanic (See Note)	03700	RC-045	Q	5541	5624
Automotive Mechanic (See Note)	03700	RC-045	S	5620	5704
Automotive Parts Warehouse	03730	RC-045	B	5141	5218
Automotive Parts Warehouse Specialist	03734	RC-045	B	5240	5319
Small Engine Mechanic	41150	RC-045	B	4711	4782
Storekeeper I (See Note)	43051	RC-045	B	5036	5112
Storekeeper II (See Note)	43052	RC-045	B	5144	5221

Effective July 1, 2011, employees who have more than 10 years of continuous service receive a longevity payment of \$50/month and employees who have more than 15 years of continuous service receive a longevity payment of \$75/month.

Note: The Storekeeper I and II titles are in Cook County only.

An employee newly hired to a position that was previously covered by the alternative formula for pension benefits prior to January 1, 2011 and, effective January 1, 2011, is covered by the standard formula for pension benefits (see the Illinois Pension Code [40 ILCS 5/1-160(g) and 14-110(b)]) shall be placed on the Pay Plan Code B salary grade assigned to the classification to which the position is allocated. An employee newly hired is an employee hired on or after January 1, 2011 who has never been a member of the State Employees' Retirement System (SERS) or any other reciprocal retirement system. Other reciprocal retirement systems are the Chicago Teachers' Pension Fund, County Employees' Annuity and Benefit Fund of Cook County, Forest Preserve District Employees' Annuity and Benefit Fund of Cook County, General Assembly Retirement System (GARS), Illinois Municipal Retirement Fund (IMRF), Judges Retirement System (JRS), Laborers' Annuity and Benefit Fund of Chicago, Metropolitan Water Reclamation

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

District Retirement Fund, Municipal Employees Annuity and Benefit Fund of Chicago, State Universities Retirement System (SURS) and Teachers' Retirement System of the State of Illinois (TRS).

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX A Negotiated Rates of Pay****Section 310.TABLE J RC-014 (Clerical Employees, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Account Clerk I	00111	RC-014	05
Account Clerk II	00112	RC-014	07
Account Technician I	00115	RC-014	10
Account Technician II	00116	RC-014	12
Administrative Services Worker Trainee	00600	RC-014	02
Aircraft Dispatcher	00951	RC-014	12
Aircraft Lead Dispatcher	00952	RC-014	14
Audio Visual Technician I	03501	RC-014	06
Audio Visual Technician II	03502	RC-014	09
Buyer Assistant	05905	RC-014	10
Check Issuance Machine Operator	06920	RC-014	09
Check Issuance Machine Supervisor	06925	RC-014	11
Clerical Trainee	08050	RC-014	TR
Communications Dispatcher	08815	RC-014	09
Communications Equipment Technician I	08831	RC-014	17
Communications Equipment Technician II	08832	RC-014	19
Communications Equipment Technician III	08833	RC-014	20
Court Reporter	09900	RC-014	15
Data Processing Assistant	11420	RC-014	06
Data Processing Operator	11425	RC-014	04
Data Processing Operator Trainee	11428	RC-014	02
Drafting Worker	12749	RC-014	11
Electronic Equipment Installer/Repairer	13340	RC-014	10
Electronic Equipment Installer/Repairer Lead Worker	13345	RC-014	12
Electronics Technician	13360	RC-014	15
Emergency Response Lead Telecommunicator	13540	RC-014	13
Emergency Response Telecommunicator	13543	RC-014	11
Engineering Technician II	13732	RC-014	13
Engineering Technician III	13733	RC-014	16
Executive Secretary I	14031	RC-014	11
Executive Secretary II	14032	RC-014	14
Executive Secretary III	14033	RC-014	16

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Graphic Arts Designer	17366	RC-014	14
Graphic Arts Designer Advanced	17370	RC-014	16
Graphic Arts Designer Supervisor	17365	RC-014	18
Graphic Arts Technician	17400	RC-014	12
Human Resources Assistant	19690	RC-014	08
Human Resources Associate	19691	RC-014	11
Industrial Commission Reporter	21080	RC-014	16
Industrial Commission Technician	21095	RC-014	11
Insurance Analyst I	21561	RC-014	09
Insurance Analyst II	21562	RC-014	12
Insurance Analyst Trainee	21566	RC-014	07
Intermittent Clerk	21686	RC-014	02H
Library Aide I	23421	RC-014	03
Library Aide II	23422	RC-014	05
Library Aide III	23423	RC-014	07
Library Technical Assistant	23450	RC-014	10
Lottery Telemarketing Representative	24520	RC-014	09
Microfilm Laboratory Technician I	27175	RC-014	07
Microfilm Laboratory Technician II	27176	RC-014	09
Microfilm Operator I	27181	RC-014	04
Microfilm Operator II	27182	RC-014	06
Microfilm Operator III	27183	RC-014	08
Office Administrator I	29991	RC-014	07
Office Administrator II	29992	RC-014	09
Office Administrator III	29993	RC-014	11
Office Aide	30005	RC-014	02
Office Assistant	30010	RC-014	06
Office Associate	30015	RC-014	08
Office Clerk	30020	RC-014	04
Office Coordinator	30025	RC-014	09
Photographer	32080	RC-014	14
<del>Photographer I</del>	<del>32085</del>	<del>RC-014</del>	<del>11</del>
<del>Photographer II</del>	<del>32086</del>	<del>RC-014</del>	<del>14</del>
<del>Photographer III</del>	<del>32087</del>	<del>RC-014</del>	<del>15</del>
Photographic Technician I	32091	RC-014	11
Photographic Technician II	32092	RC-014	14
Photographic Technician III	32093	RC-014	15
Procurement Representative	34540	RC-014	09
Property and Supply Clerk I	34791	RC-014	03.5

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Property and Supply Clerk II	34792	RC-014	05.5
Property and Supply Clerk III	34793	RC-014	08
Rehabilitation Case Coordinator I	38141	RC-014	08
Rehabilitation Case Coordinator II	38142	RC-014	10
Reproduction Service Supervisor I	38201	RC-014	13
Reproduction Service Technician I	38203	RC-014	05
Reproduction Service Technician II	38204	RC-014	09
Reproduction Service Technician III	38205	RC-014	11
Safety Responsibility Analyst	38910	RC-014	12
Safety Responsibility Analyst Supervisor	38915	RC-014	14
Storekeeper I	43051	RC-014	10.5
Storekeeper II	43052	RC-014	12.5
Storekeeper III	43053	RC-014	14
Stores Clerk	43060	RC-014	04.5
Switchboard Operator I	44411	RC-014	05
Switchboard Operator II	44412	RC-014	07
Switchboard Operator III	44413	RC-014	09
Telecommunications Supervisor	45305	RC-014	20
Telecommunicator	45321	RC-014	12
Telecommunicator – Command Center	45316	RC-014	13
Telecommunicator Call Taker	45322	RC-014	14
Telecommunicator Lead Call Taker	45323	RC-014	16
Telecommunicator Lead Specialist	45327	RC-014	17
Telecommunicator Lead Worker	45324	RC-014	14
Telecommunicator Lead Worker – Command Center	45318	RC-014	15
Telecommunicator Specialist	45326	RC-014	15
Telecommunicator Trainee	45325	RC-014	10
Vehicle Permit Evaluator	47585	RC-014	11
Veterans Service Officer Associate	47804	RC-014	13

NOTE: RC-014-TR is at least the minimum wage and below the minimum rate in the pay grade of the targeted title. The targeted title is the lowest entry level position in the office, either Office Aide (pay grade RC-014-02), Office Clerk (pay grade RC-014-04) or, for the Department of Corrections only, Office Assistant (pay grade RC-014-06).

Effective July 1, 2013, the Step 8 rate shall be increased by \$25.00 per month to \$75.00 a month for those employees who attain ten (10) years of continuous service and have three (3) or more years of creditable service on Step 8 in the same or higher pay grade

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

on or before July 1, 2013. For those employees who attain fifteen (15) years of continuous service and have three (3) or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2013, the Step 8 rate shall be increased by \$25.00 per month to \$100.00 a month. Employees whose salaries are red-circled above the maximum Step rate continue to receive all applicable general increases and any other adjustments (except the longevity pay) provided for in the Agreement. For these employees, the longevity pay shall be limited to the amount that would increase the employee's salary to the amount that is equal to that of an employee on the maximum Step rate with the same number of years of continuous and creditable service. Employees receiving the longevity pay shall continue to receive the longevity pay as long as they remain in the same or successor classification as a result of a reclassification or reevaluation. Employees who are eligible for the increase provided for longevity pay on or before January 1, 2002, shall continue to receive longevity pay after being placed on Step 8 while they remain in the same or lower pay grade.

**Effective July 1, 2012**  
**Bargaining Unit: RC-014**

Pay Grade	Pay Plan Code	STEPS							
		1	2	3	4	5	6	7	8
02	B	2662	2721	2783	2856	2919	2989	3100	3222
02	Q	2762	2828	2891	2966	3039	3108	3222	3352
02	S	2839	2898	2961	3041	3111	3178	3295	3426
02H	B	16.38	16.74	17.13	17.58	17.96	18.39	19.08	19.83
02H	Q	17.00	17.40	17.79	18.25	18.70	19.13	19.83	20.63
02H	S	17.47	17.83	18.22	18.71	19.14	19.56	20.28	21.08
03	B	2721	2783	2857	2924	2995	3066	3193	3320
03	Q	2828	2891	2967	3042	3113	3185	3320	3455
03	S	2898	2961	3042	3114	3183	3257	3392	3526
03.5	B	2783	2852	2924	2997	3066	3144	3276	3406
03.5	Q	2891	2963	3042	3115	3185	3266	3405	3542
03.5	S	2961	3039	3114	3188	3257	3338	3479	3619
04	B	2783	2857	2934	2999	3082	3152	3285	3419

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

04	Q	2891	2967	3046	3117	3205	3276	3416	3553
04	S	2961	3042	3118	3192	3278	3348	3487	3628
04.5	B	2852	2924	2998	3076	3157	3229	3366	3500
04.5	Q	2963	3042	3116	3199	3281	3359	3501	3641
04.5	S	3039	3114	3191	3268	3352	3432	3576	3718
05	B	2857	2939	3012	3091	3166	3245	3378	3513
05	Q	2967	3050	3131	3212	3291	3374	3513	3652
05	S	3042	3120	3205	3286	3366	3446	3585	3728
05.5	B	2924	2999	3088	3165	3245	3329	3466	3602
05.5	Q	3042	3117	3210	3290	3374	3466	3603	3747
05.5	S	3114	3192	3283	3365	3446	3536	3677	3823
06	B	2939	3014	3095	3181	3262	3354	3495	3634
06	Q	3050	3132	3219	3309	3395	3485	3634	3780
06	S	3120	3206	3288	3383	3469	3560	3710	3860
07	B	3014	3100	3191	3280	3368	3464	3621	3765
07	Q	3132	3222	3318	3409	3504	3602	3770	3921
07	S	3206	3295	3388	3482	3578	3673	3845	3997
08	B	3100	3198	3291	3395	3487	3586	3756	3907
08	Q	3222	3327	3422	3533	3627	3737	3912	4070
08	S	3295	3396	3495	3607	3705	3811	3987	4146
09	B	3198	3297	3402	3507	3620	3726	3903	4059
09	Q	3327	3429	3540	3649	3768	3880	4066	4230
09	S	3396	3500	3613	3724	3844	3956	4143	4310
10	B	3300	3421	3522	3638	3753	3869	4067	4231
10	Q	3433	3558	3666	3791	3909	4032	4246	4416
10	S	3504	3629	3740	3864	3983	4114	4325	4497

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

10.5	B	3398	3507	3627	3738	3868	3981	4185	4353
10.5	Q	3537	3649	3777	3895	4030	4150	4365	4541
10.5	S	3610	3724	3854	3968	4113	4232	4449	4629
11	B	3422	3538	3652	3785	3909	4031	4244	4414
11	Q	3560	3687	3807	3943	4075	4203	4431	4607
11	S	3630	3758	3879	4019	4151	4283	4510	4689
12	B	3560	3691	3811	3954	4083	4234	4461	4638
12	Q	3706	3843	3970	4123	4263	4417	4658	4845
12	S	3778	3916	4044	4201	4344	4499	4741	4932
12.5	B	3644	3779	3910	4060	4198	4336	4574	4756
12.5	Q	3796	3937	4077	4234	4384	4526	4781	4969
12.5	S	3869	4014	4153	4317	4466	4607	4864	5057
13	B	3694	3829	3975	4124	4274	4435	4681	4867
13	Q	3847	3987	4144	4307	4465	4629	4892	5088
13	S	3920	4065	4225	4389	4543	4712	4976	5175
14	B	3852	3997	4153	4336	4493	4664	4937	5134
14	Q	4016	4168	4339	4526	4696	4876	5159	5364
14	S	4090	4250	4416	4607	4779	4959	5241	5448
15	B	4005	4182	4354	4524	4708	4884	5178	5383
15	Q	4179	4362	4543	4727	4923	5104	5408	5626
15	S	4256	4443	4624	4810	5006	5186	5493	5712
16	B	4192	4379	4574	4762	4962	5160	5465	5683
16	Q	4374	4574	4781	4980	5185	5392	5713	5944
16	S	4458	4655	4864	5065	5268	5477	5793	6024
17	B	4392	4594	4805	5010	5213	5424	5747	5976
17	Q	4582	4802	5024	5232	5445	5669	6005	6248
17	S	4665	4887	5108	5319	5529	5750	6093	6335

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

18	B	4623	4845	5070	5302	5517	5739	6080	6325
18	Q	4828	5067	5301	5542	5768	5998	6358	6611
18	S	4908	5147	5383	5625	5852	6084	6437	6696
19	B	4871	5119	5361	5608	5847	6090	6461	6719
19	Q	5091	5352	5599	5866	6110	6367	6750	7021
19	S	5177	5436	5685	5949	6195	6450	6833	7106
20	B	5146	5407	5657	5927	6185	6441	6832	7105
20	Q	5378	5649	5916	6197	6463	6731	7143	7428
20	S	5464	5733	5998	6278	6545	6815	7223	7512

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**Effective May 20, 2013**  
**Bargaining Unit: RC-014**

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
2	B	2422	2502	2582	2662	2721	2783	2856	2919	2989	3100	3222
2	Q	2513	2596	2679	2762	2828	2891	2966	3039	3108	3222	3352
2	S	2583	2669	2754	2839	2898	2961	3041	3111	3178	3295	3426
02H	B	14.90	15.40	15.89	16.38	16.74	17.13	17.58	17.96	18.39	19.08	19.83
02H	Q	15.46	15.98	16.49	17.00	17.40	17.79	18.25	18.70	19.13	19.83	20.63
02H	S	15.90	16.42	16.95	17.47	17.83	18.22	18.71	19.14	19.56	20.28	21.08
3	B	2476	2558	2639	2721	2783	2857	2924	2995	3066	3193	3320
3	Q	2573	2658	2743	2828	2891	2967	3042	3113	3185	3320	3455
3	S	2637	2724	2811	2898	2961	3042	3114	3183	3257	3392	3526
3.5	B	2533	2616	2700	2783	2852	2924	2997	3066	3144	3276	3406

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

3.5	Q	2631	2718	2804	2891	2963	3042	3115	3185	3266	3405	3542
3.5	S	2695	2783	2872	2961	3039	3114	3188	3257	3338	3479	3619
4	B	2533	2616	2700	2783	2857	2934	2999	3082	3152	3285	3419
4	Q	2631	2718	2804	2891	2967	3046	3117	3205	3276	3416	3553
4	S	2695	2783	2872	2961	3042	3118	3192	3278	3348	3487	3628
4.5	B	2595	2681	2766	2852	2924	2998	3076	3157	3229	3366	3500
4.5	Q	2696	2785	2874	2963	3042	3116	3199	3281	3359	3501	3641
4.5	S	2765	2857	2948	3039	3114	3191	3268	3352	3432	3576	3718
5	B	2600	2686	2771	2857	2939	3012	3091	3166	3245	3378	3513
5	Q	2700	2789	2878	2967	3050	3131	3212	3291	3374	3513	3652
5	S	2768	2859	2951	3042	3120	3205	3286	3366	3446	3585	3728
5.5	B	2661	2749	2836	2924	2999	3088	3165	3245	3329	3466	3602
5.5	Q	2768	2859	2951	3042	3117	3210	3290	3374	3466	3603	3747
5.5	S	2834	2927	3021	3114	3192	3283	3365	3446	3536	3677	3823
6	B	2674	2763	2851	2939	3014	3095	3181	3262	3354	3495	3634
6	Q	2776	2867	2959	3050	3132	3219	3309	3395	3485	3634	3780
6	S	2839	2933	3026	3120	3206	3288	3383	3469	3560	3710	3860
7	B	2743	2833	2924	3014	3100	3191	3280	3368	3464	3621	3765
7	Q	2850	2944	3038	3132	3222	3318	3409	3504	3602	3770	3921
7	S	2917	3014	3110	3206	3295	3388	3482	3578	3673	3845	3997
8	B	2821	2914	3007	3100	3198	3291	3395	3487	3586	3756	3907
8	Q	2932	3029	3125	3222	3327	3422	3533	3627	3737	3912	4070
8	S	2998	3097	3196	3295	3396	3495	3607	3705	3811	3987	4146
9	B	2910	3006	3102	3198	3297	3402	3507	3620	3726	3903	4059
9	Q	3028	3127	3227	3327	3429	3540	3649	3768	3880	4066	4230
9	S	3090	3192	3294	3396	3500	3613	3724	3844	3956	4143	4310

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

10	B	3003	3102	3201	3300	3421	3522	3638	3753	3869	4067	4231
10	Q	3124	3227	3330	3433	3558	3666	3791	3909	4032	4246	4416
10	S	3189	3294	3399	3504	3629	3740	3864	3983	4114	4325	4497
10.5	B	3092	3194	3296	3398	3507	3627	3738	3868	3981	4185	4353
10.5	Q	3219	3325	3431	3537	3649	3777	3895	4030	4150	4365	4541
10.5	S	3285	3393	3502	3610	3724	3854	3968	4113	4232	4449	4629
11	B	3114	3217	3319	3422	3538	3652	3785	3909	4031	4244	4414
11	Q	3240	3346	3453	3560	3687	3807	3943	4075	4203	4431	4607
11	S	3303	3412	3521	3630	3758	3879	4019	4151	4283	4510	4689
12	B	3240	3346	3453	3560	3691	3811	3954	4083	4234	4461	4638
12	Q	3372	3484	3595	3706	3843	3970	4123	4263	4417	4658	4845
12	S	3438	3551	3665	3778	3916	4044	4201	4344	4499	4741	4932
12.5	B	3316	3425	3535	3644	3779	3910	4060	4198	4336	4574	4756
12.5	Q	3454	3568	3682	3796	3937	4077	4234	4384	4526	4781	4969
12.5	S	3521	3637	3753	3869	4014	4153	4317	4466	4607	4864	5057
13	B	3362	3472	3583	3694	3829	3975	4124	4274	4435	4681	4867
13	Q	3501	3616	3732	3847	3987	4144	4307	4465	4629	4892	5088
13	S	3567	3685	3802	3920	4065	4225	4389	4543	4712	4976	5175
14	B	3505	3621	3736	3852	3997	4153	4336	4493	4664	4937	5134
14	Q	3655	3775	3896	4016	4168	4339	4526	4696	4876	5159	5364
14	S	3722	3845	3967	4090	4250	4416	4607	4779	4959	5241	5448
15	B	3645	3765	3885	4005	4182	4354	4524	4708	4884	5178	5383
15	Q	3803	3928	4054	4179	4362	4543	4727	4923	5104	5408	5626
15	S	3873	4001	4128	4256	4443	4624	4810	5006	5186	5493	5712
16	B	3815	3940	4066	4192	4379	4574	4762	4962	5160	5465	5683
16	Q	3980	4112	4243	4374	4574	4781	4980	5185	5392	5713	5944
16	S	4057	4191	4324	4458	4655	4864	5065	5268	5477	5793	6024

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

17	B	3997	4128	4260	4392	4594	4805	5010	5213	5424	5747	5976
17	Q	4170	4307	4445	4582	4802	5024	5232	5445	5669	6005	6248
17	S	4245	4385	4525	4665	4887	5108	5319	5529	5750	6093	6335
18	B	4207	4346	4484	4623	4845	5070	5302	5517	5739	6080	6325
18	Q	4393	4538	4683	4828	5067	5301	5542	5768	5998	6358	6611
18	S	4466	4614	4761	4908	5147	5383	5625	5852	6084	6437	6696
19	B	4433	4579	4725	4871	5119	5361	5608	5847	6090	6461	6719
19	Q	4633	4786	4938	5091	5352	5599	5866	6110	6367	6750	7021
19	S	4711	4866	5022	5177	5436	5685	5949	6195	6450	6833	7106
20	B	4683	4837	4992	5146	5407	5657	5927	6185	6441	6832	7105
20	Q	4894	5055	5217	5378	5649	5916	6197	6463	6731	7143	7428
20	S	4972	5136	5300	5464	5733	5998	6278	6545	6815	7223	7512

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**Effective July 1, 2013**  
**Bargaining Unit: RC-014**

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
2	B	2470	2552	2634	2715	2775	2839	2913	2977	3049	3162	3286
2	Q	2563	2648	2733	2817	2885	2949	3025	3100	3170	3286	3419
2	S	2635	2722	2809	2896	2956	3020	3102	3173	3242	3361	3495
02H	B	15.20	15.70	16.21	16.71	17.08	17.47	17.93	18.32	18.76	19.46	20.22
02H	Q	15.77	16.30	16.82	17.34	17.75	18.15	18.62	19.08	19.51	20.22	21.04
02H	S	16.22	16.75	17.29	17.82	18.19	18.58	19.09	19.53	19.95	20.68	21.51
3	B	2526	2609	2692	2775	2839	2914	2982	3055	3127	3257	3386
3	Q	2624	2711	2798	2885	2949	3026	3103	3175	3249	3386	3524

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

3	S	2690	2778	2867	2956	3020	3103	3176	3247	3322	3460	3597
3.5	B	2584	2668	2754	2839	2909	2982	3057	3127	3207	3342	3474
3.5	Q	2684	2772	2860	2949	3022	3103	3177	3249	3331	3473	3613
3.5	S	2749	2839	2929	3020	3100	3176	3252	3322	3405	3549	3691
4	B	2584	2668	2754	2839	2914	2993	3059	3144	3215	3351	3487
4	Q	2684	2772	2860	2949	3026	3107	3179	3269	3342	3484	3624
4	S	2749	2839	2929	3020	3103	3180	3256	3344	3415	3557	3701
4.5	B	2647	2735	2821	2909	2982	3058	3138	3220	3294	3433	3570
4.5	Q	2750	2841	2931	3022	3103	3178	3263	3347	3426	3571	3714
4.5	S	2820	2914	3007	3100	3176	3255	3333	3419	3501	3648	3792
5	B	2652	2740	2826	2914	2998	3072	3153	3229	3310	3446	3583
5	Q	2754	2845	2936	3026	3111	3194	3276	3357	3441	3583	3725
5	S	2823	2916	3010	3103	3182	3269	3352	3433	3515	3657	3803
5.5	B	2714	2804	2893	2982	3059	3150	3228	3310	3396	3535	3674
5.5	Q	2823	2916	3010	3103	3179	3274	3356	3441	3535	3675	3822
5.5	S	2891	2986	3081	3176	3256	3349	3432	3515	3607	3751	3899
6	B	2727	2818	2908	2998	3074	3157	3245	3327	3421	3565	3707
6	Q	2832	2924	3018	3111	3195	3283	3375	3463	3555	3707	3856
6	S	2896	2992	3087	3182	3270	3354	3451	3538	3631	3784	3937
7	B	2798	2890	2982	3074	3162	3255	3346	3435	3533	3693	3840
7	Q	2907	3003	3099	3195	3286	3384	3477	3574	3674	3845	3999
7	S	2975	3074	3172	3270	3361	3456	3552	3650	3746	3922	4077
8	B	2877	2972	3067	3162	3262	3357	3463	3557	3658	3831	3985
8	Q	2991	3090	3188	3286	3394	3490	3604	3700	3812	3990	4151
8	S	3058	3159	3260	3361	3464	3565	3679	3779	3887	4067	4229
9	B	2968	3066	3164	3262	3363	3470	3577	3692	3801	3981	4140

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

9	Q	3089	3190	3292	3394	3498	3611	3722	3843	3958	4147	4315
9	S	3152	3256	3360	3464	3570	3685	3798	3921	4035	4226	4396
10	B	3063	3164	3265	3366	3489	3592	3711	3828	3946	4148	4316
10	Q	3186	3292	3397	3502	3629	3739	3867	3987	4113	4331	4504
10	S	3253	3360	3467	3574	3702	3815	3941	4063	4196	4412	4587
10.5	B	3154	3258	3362	3466	3577	3700	3813	3945	4061	4269	4440
10.5	Q	3283	3392	3500	3608	3722	3853	3973	4111	4233	4452	4632
10.5	S	3351	3461	3572	3682	3798	3931	4047	4195	4317	4538	4722
11	B	3176	3281	3385	3490	3609	3725	3861	3987	4112	4329	4502
11	Q	3305	3413	3522	3631	3761	3883	4022	4157	4287	4520	4699
11	S	3369	3480	3591	3703	3833	3957	4099	4234	4369	4600	4783
12	B	3305	3413	3522	3631	3765	3887	4033	4165	4319	4550	4731
12	Q	3439	3554	3667	3780	3920	4049	4205	4348	4505	4751	4942
12	S	3507	3622	3738	3854	3994	4125	4285	4431	4589	4836	5031
12.5	B	3382	3494	3606	3717	3855	3988	4141	4282	4423	4665	4851
12.5	Q	3523	3639	3756	3872	4016	4159	4319	4472	4617	4877	5068
12.5	S	3591	3710	3828	3946	4094	4236	4403	4555	4699	4961	5158
13	B	3429	3541	3655	3768	3906	4055	4206	4359	4524	4775	4964
13	Q	3571	3688	3807	3924	4067	4227	4393	4554	4722	4990	5190
13	S	3638	3759	3878	3998	4146	4310	4477	4634	4806	5076	5279
14	B	3575	3693	3811	3929	4077	4236	4423	4583	4757	5036	5237
14	Q	3728	3851	3974	4096	4251	4426	4617	4790	4974	5262	5471
14	S	3796	3922	4046	4172	4335	4504	4699	4875	5058	5346	5557
15	B	3718	3840	3963	4085	4266	4441	4614	4802	4982	5282	5491
15	Q	3879	4007	4135	4263	4449	4634	4822	5021	5206	5516	5739
15	S	3950	4081	4211	4341	4532	4716	4906	5106	5290	5603	5826

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

16	B	3891	4019	4147	4276	4467	4665	4857	5061	5263	5574	5797
16	Q	4060	4194	4328	4461	4665	4877	5080	5289	5500	5827	6063
16	S	4138	4275	4410	4547	4748	4961	5166	5373	5587	5909	6144
17	B	4077	4211	4345	4480	4686	4901	5110	5317	5532	5862	6096
17	Q	4253	4393	4534	4674	4898	5124	5337	5554	5782	6125	6373
17	S	4330	4473	4616	4758	4985	5210	5425	5640	5865	6215	6462
18	B	4291	4433	4574	4715	4942	5171	5408	5627	5854	6202	6452
18	Q	4481	4629	4777	4925	5168	5407	5653	5883	6118	6485	6743
18	S	4555	4706	4856	5006	5250	5491	5738	5969	6206	6566	6830
19	B	4522	4671	4820	4968	5221	5468	5720	5964	6212	6590	6853
19	Q	4726	4882	5037	5193	5459	5711	5983	6232	6494	6885	7161
19	S	4805	4963	5122	5281	5545	5799	6068	6319	6579	6970	7248
20	B	4777	4934	5092	5249	5515	5770	6046	6309	6570	6969	7247
20	Q	4992	5156	5321	5486	5762	6034	6321	6592	6866	7286	7577
20	S	5071	5239	5406	5573	5848	6118	6404	6676	6951	7367	7662

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**Effective July 1, 2014**  
**Bargaining Unit: RC-014**

Pay Grade	Pay Plan Code	STEPS										
		1c	1b	1a	1	2	3	4	5	6	7	8
2	B	2519	2603	2687	2769	2831	2896	2971	3037	3110	3225	3352
2	Q	2614	2701	2788	2873	2943	3008	3086	3162	3233	3352	3487
2	S	2688	2776	2865	2954	3015	3080	3164	3236	3307	3428	3565
02H	B	15.50	16.02	16.54	17.04	17.42	17.82	18.28	18.69	19.14	19.85	20.63
02H	Q	16.09	16.62	17.16	17.68	18.11	18.51	18.99	19.46	19.90	20.63	21.46
02H	S	16.54	17.08	17.63	18.18	18.55	18.95	19.47	19.91	20.35	21.10	21.94

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

3	B	2577	2661	2746	2831	2896	2972	3042	3116	3190	3322	3454
3	Q	2676	2765	2854	2943	3008	3087	3165	3239	3314	3454	3594
3	S	2744	2834	2924	3015	3080	3165	3240	3312	3388	3529	3669
3.5	B	2636	2721	2809	2896	2967	3042	3118	3190	3271	3409	3543
3.5	Q	2738	2827	2917	3008	3082	3165	3241	3314	3398	3542	3685
3.5	S	2804	2896	2988	3080	3162	3240	3317	3388	3473	3620	3765
4	B	2636	2721	2809	2896	2972	3053	3120	3207	3279	3418	3557
4	Q	2738	2827	2917	3008	3087	3169	3243	3334	3409	3554	3696
4	S	2804	2896	2988	3080	3165	3244	3321	3411	3483	3628	3775
4.5	B	2700	2790	2877	2967	3042	3119	3201	3284	3360	3502	3641
4.5	Q	2805	2898	2990	3082	3165	3242	3328	3414	3495	3642	3788
4.5	S	2876	2972	3067	3162	3240	3320	3400	3487	3571	3721	3868
5	B	2705	2795	2883	2972	3058	3133	3216	3294	3376	3515	3655
5	Q	2809	2902	2995	3087	3173	3258	3342	3424	3510	3655	3800
5	S	2879	2974	3070	3165	3246	3334	3419	3502	3585	3730	3879
5.5	B	2768	2860	2951	3042	3120	3213	3293	3376	3464	3606	3747
5.5	Q	2879	2974	3070	3165	3243	3339	3423	3510	3606	3749	3898
5.5	S	2949	3046	3143	3240	3321	3416	3501	3585	3679	3826	3977
6	B	2782	2874	2966	3058	3135	3220	3310	3394	3489	3636	3781
6	Q	2889	2982	3078	3173	3259	3349	3443	3532	3626	3781	3933
6	S	2954	3052	3149	3246	3335	3421	3520	3609	3704	3860	4016
7	B	2854	2948	3042	3135	3225	3320	3413	3504	3604	3767	3917
7	Q	2965	3063	3161	3259	3352	3452	3547	3645	3747	3922	4079
7	S	3035	3135	3235	3335	3428	3525	3623	3723	3821	4000	4159
8	B	2935	3031	3128	3225	3327	3424	3532	3628	3731	3908	4065
8	Q	3051	3152	3252	3352	3462	3560	3676	3774	3888	4070	4234

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

8	S	3119	3222	3325	3428	3533	3636	3753	3855	3965	4148	4314
9	B	3027	3127	3227	3327	3430	3539	3649	3766	3877	4061	4223
9	Q	3151	3254	3358	3462	3568	3683	3796	3920	4037	4230	4401
9	S	3215	3321	3427	3533	3641	3759	3874	3999	4116	4311	4484
10	B	3124	3227	3330	3433	3559	3664	3785	3905	4025	4231	4402
10	Q	3250	3358	3465	3572	3702	3814	3944	4067	4195	4418	4594
10	S	3318	3427	3536	3645	3776	3891	4020	4144	4280	4500	4679
10.5	B	3217	3323	3429	3535	3649	3774	3889	4024	4142	4354	4529
10.5	Q	3349	3460	3570	3680	3796	3930	4052	4193	4318	4541	4725
10.5	S	3418	3530	3643	3756	3874	4010	4128	4279	4403	4629	4816
11	B	3240	3347	3453	3560	3681	3800	3938	4067	4194	4416	4592
11	Q	3371	3481	3592	3704	3836	3961	4102	4240	4373	4610	4793
11	S	3436	3550	3663	3777	3910	4036	4181	4319	4456	4692	4879
12	B	3371	3481	3592	3704	3840	3965	4114	4248	4405	4641	4826
12	Q	3508	3625	3740	3856	3998	4130	4289	4435	4595	4846	5041
12	S	3577	3694	3813	3931	4074	4208	4371	4520	4681	4933	5132
12.5	B	3450	3564	3678	3791	3932	4068	4224	4368	4511	4758	4948
12.5	Q	3593	3712	3831	3949	4096	4242	4405	4561	4709	4975	5169
12.5	S	3663	3784	3905	4025	4176	4321	4491	4646	4793	5060	5261
13	B	3498	3612	3728	3843	3984	4136	4290	4446	4614	4871	5063
13	Q	3642	3762	3883	4002	4148	4312	4481	4645	4816	5090	5294
13	S	3711	3834	3956	4078	4229	4396	4567	4727	4902	5178	5385
14	B	3647	3767	3887	4008	4159	4321	4511	4675	4852	5137	5342
14	Q	3803	3928	4053	4178	4336	4515	4709	4886	5073	5367	5580
14	S	3872	4000	4127	4255	4422	4594	4793	4973	5159	5453	5668
15	B	3792	3917	4042	4167	4351	4530	4706	4898	5082	5388	5601

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

15	Q	3957	4087	4218	4348	4538	4727	4918	5121	5310	5626	5854
15	S	4029	4163	4295	4428	4623	4810	5004	5208	5396	5715	5943
16	B	3969	4099	4230	4362	4556	4758	4954	5162	5368	5685	5913
16	Q	4141	4278	4415	4550	4758	4975	5182	5395	5610	5944	6184
16	S	4221	4361	4498	4638	4843	5060	5269	5480	5699	6027	6267
17	B	4159	4295	4432	4570	4780	4999	5212	5423	5643	5979	6218
17	Q	4338	4481	4625	4767	4996	5226	5444	5665	5898	6248	6500
17	S	4417	4562	4708	4853	5085	5314	5534	5753	5982	6339	6591
18	B	4377	4522	4665	4809	5041	5274	5516	5740	5971	6326	6581
18	Q	4571	4722	4873	5024	5271	5515	5766	6001	6240	6615	6878
18	S	4646	4800	4953	5106	5355	5601	5853	6088	6330	6697	6967
19	B	4612	4764	4916	5067	5325	5577	5834	6083	6336	6722	6990
19	Q	4821	4980	5138	5297	5568	5825	6103	6357	6624	7023	7304
19	S	4901	5062	5224	5387	5656	5915	6189	6445	6711	7109	7393
20	B	4873	5033	5194	5354	5625	5885	6167	6435	6701	7108	7392
20	Q	5092	5259	5427	5596	5877	6155	6447	6724	7003	7432	7729
20	S	5172	5344	5514	5684	5965	6240	6532	6810	7090	7514	7815

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(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX A Negotiated Rates of Pay****Section 310.TABLE S VR-704 (Departments of Corrections, Financial and Professional Regulation, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Clinical Services Supervisor	08260	VR-704	24
Forensic Science Administrator I	15911	VR-704	24
Forensic Science Administrator II	15912	VR-704	25
Juvenile Justice Chief of Security	21965	VR-704	24
Police Lieutenant	32977	VR-704	24
Public Service Administrator, Option 7 (inspector sworn and sex offender registry supervisor non-sworn functions at Department of State Police)	37015	VR-704	26
Public Service Administrator, Options 7 (criminal intelligence analyst supervisor, strategic management policy administrator, firearms specialist, computer evidence recovery specialist, and narcotics and currency unit supervisor non-sworn functions at Department of State Police, statewide enforcement function at Department of Financial and Professional Regulation, and superintendent, operations center supervisor and training academy supervisor functions at Department of Corrections) and 8K (Departments of Corrections, Human Services and Juvenile Justice)	37015	VR-704	25
Public Service Administrator, Options 7 (women and family services coordinator, district supervisor, staff assistant and deputy commander of intelligence functions at Department of Corrections and investigator function at Department of Human Services in the Office of the Inspector General), 8L (at Departments of Corrections and State Police) and 8J (dietary manager function at Department of Corrections)	37015	VR-704	24

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Senior Public Service Administrator, Option 7 (research and development unit chief function at Department of State Police)	40070	VR-704	24
Senior Public Service Administrator, Option 7 (protected services unit operations commander and senior terrorism advisor functions at Department of State Police)	40070	VR-704	25
Senior Public Service Administrator, Option 7 (assistant director of forensic science training, quality assurance and safety director and section chief functions at Department of State Police)	40070	VR-704	26
Senior Public Service Administrator, Option 7 (deputy laboratory director function at Department of State Police)	40070	VR-704	27
Shift Supervisor	40800	VR-704	24
<u>Shift Supervisor – Hired on or after August 1, 2010</u>	<u>40800</u>	<u>VR-704</u>	<u>23</u>

NOTE: The positions allocated to the Public Service Administrator title that are assigned to the negotiated VR-704 pay grade have the following Options: 7; 8J; 8K; and 8L. The positions allocated to the Senior Public Service Administrator title that are assigned to the negotiated VR-704 pay grade have the Option 7. See the definition of option in Section 310.50.

**Effective August 1, 2010**  
**Bargaining Unit: VR-704**

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>STEPS</u>								
		<u>1a</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
<u>23</u>	<u>Q</u>	<u>5820</u>	<u>5995</u>	<u>6314</u>	<u>6641</u>	<u>6962</u>	<u>7280</u>	<u>7610</u>	<u>8089</u>	<u>8412</u>
<u>23</u>	<u>S</u>	<u>5892</u>	<u>6069</u>	<u>6385</u>	<u>6715</u>	<u>7034</u>	<u>7356</u>	<u>7686</u>	<u>8161</u>	<u>8487</u>
<u>24</u>	<u>B</u>	<u>5860</u>	<u>6036</u>	<u>6357</u>	<u>6691</u>	<u>7010</u>	<u>7335</u>	<u>7665</u>	<u>8147</u>	<u>8472</u>
<u>24</u>	<u>Q</u>	<u>6126</u>	<u>6310</u>	<u>6646</u>	<u>6991</u>	<u>7328</u>	<u>7663</u>	<u>8011</u>	<u>8515</u>	<u>8855</u>
<u>24</u>	<u>S</u>	<u>6202</u>	<u>6388</u>	<u>6721</u>	<u>7068</u>	<u>7404</u>	<u>7743</u>	<u>8091</u>	<u>8590</u>	<u>8934</u>

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>25</u>	<u>B</u>	<u>6246</u>	<u>6434</u>	<u>6785</u>	<u>7143</u>	<u>7500</u>	<u>7856</u>	<u>8214</u>	<u>8740</u>	<u>9091</u>
<u>25</u>	<u>Q</u>	<u>6525</u>	<u>6722</u>	<u>7091</u>	<u>7462</u>	<u>7840</u>	<u>8213</u>	<u>8584</u>	<u>9135</u>	<u>9501</u>
<u>25</u>	<u>S</u>	<u>6609</u>	<u>6801</u>	<u>7170</u>	<u>7540</u>	<u>7915</u>	<u>8288</u>	<u>8659</u>	<u>9213</u>	<u>9582</u>
<u>26</u>	<u>B</u>	<u>6605</u>	<u>6866</u>	<u>7241</u>	<u>7626</u>	<u>8012</u>	<u>8385</u>	<u>8762</u>	<u>9328</u>	<u>9700</u>
<u>26</u>	<u>Q</u>	<u>6917</u>	<u>7196</u>	<u>7587</u>	<u>7989</u>	<u>8393</u>	<u>8785</u>	<u>9177</u>	<u>9772</u>	<u>10162</u>

**Effective September 29, 2010**  
**Bargaining Unit: VR-704**

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>S T E P S</u>								
		<u>1a</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
<u>23</u>	<u>Q</u>	<u>5820</u>	<u>5995</u>	<u>6314</u>	<u>6641</u>	<u>6962</u>	<u>7280</u>	<u>7610</u>	<u>8089</u>	<u>8412</u>
<u>23</u>	<u>S</u>	<u>5892</u>	<u>6069</u>	<u>6385</u>	<u>6715</u>	<u>7034</u>	<u>7356</u>	<u>7686</u>	<u>8161</u>	<u>8487</u>
<u>24</u>	<u>B</u>	<u>5860</u>	<u>6036</u>	<u>6357</u>	<u>6691</u>	<u>7010</u>	<u>7335</u>	<u>7665</u>	<u>8147</u>	<u>8472</u>
<u>24</u>	<u>Q</u>	<u>6126</u>	<u>6310</u>	<u>6646</u>	<u>6991</u>	<u>7328</u>	<u>7663</u>	<u>8011</u>	<u>8515</u>	<u>8855</u>
<u>24</u>	<u>S</u>	<u>6202</u>	<u>6388</u>	<u>6721</u>	<u>7068</u>	<u>7404</u>	<u>7743</u>	<u>8091</u>	<u>8590</u>	<u>8934</u>
<u>25</u>	<u>B</u>	<u>6246</u>	<u>6434</u>	<u>6785</u>	<u>7143</u>	<u>7500</u>	<u>7856</u>	<u>8214</u>	<u>8740</u>	<u>9091</u>
<u>25</u>	<u>Q</u>	<u>6525</u>	<u>6722</u>	<u>7091</u>	<u>7462</u>	<u>7840</u>	<u>8213</u>	<u>8584</u>	<u>9135</u>	<u>9501</u>
<u>25</u>	<u>S</u>	<u>6609</u>	<u>6801</u>	<u>7170</u>	<u>7540</u>	<u>7915</u>	<u>8288</u>	<u>8659</u>	<u>9213</u>	<u>9582</u>
<u>26</u>	<u>B</u>	<u>6605</u>	<u>6866</u>	<u>7241</u>	<u>7626</u>	<u>8012</u>	<u>8385</u>	<u>8762</u>	<u>9328</u>	<u>9700</u>
<u>26</u>	<u>Q</u>	<u>6917</u>	<u>7196</u>	<u>7587</u>	<u>7989</u>	<u>8393</u>	<u>8785</u>	<u>9177</u>	<u>9772</u>	<u>10162</u>
<u>27</u>	<u>B</u>	<u>6979</u>	<u>7329</u>	<u>7728</u>	<u>8136</u>	<u>8548</u>	<u>8948</u>	<u>9350</u>	<u>9954</u>	<u>10353</u>

**Effective January 1, 2011**  
**Bargaining Unit: VR-704**

<u>Pay</u>	<u>Pay</u>	<u>S T E P S</u>								
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## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>Grade</u>	<u>Plan Code</u>	<u>1a</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
<u>23</u>	<u>Q</u>	<u>5820</u>	<u>5995</u>	<u>6314</u>	<u>6641</u>	<u>6962</u>	<u>7280</u>	<u>7610</u>	<u>8089</u>	<u>8412</u>
<u>23</u>	<u>S</u>	<u>5892</u>	<u>6069</u>	<u>6385</u>	<u>6715</u>	<u>7034</u>	<u>7356</u>	<u>7686</u>	<u>8161</u>	<u>8487</u>
<u>24</u>	<u>B</u>	<u>5860</u>	<u>6036</u>	<u>6357</u>	<u>6691</u>	<u>7010</u>	<u>7335</u>	<u>7665</u>	<u>8147</u>	<u>8472</u>
<u>24</u>	<u>Q</u>	<u>6126</u>	<u>6310</u>	<u>6646</u>	<u>6991</u>	<u>7328</u>	<u>7663</u>	<u>8011</u>	<u>8515</u>	<u>8855</u>
<u>24</u>	<u>S</u>	<u>6202</u>	<u>6388</u>	<u>6721</u>	<u>7068</u>	<u>7404</u>	<u>7743</u>	<u>8091</u>	<u>8590</u>	<u>8934</u>
<u>25</u>	<u>B</u>	<u>6246</u>	<u>6434</u>	<u>6785</u>	<u>7143</u>	<u>7500</u>	<u>7856</u>	<u>8214</u>	<u>8740</u>	<u>9091</u>
<u>25</u>	<u>Q</u>	<u>6525</u>	<u>6722</u>	<u>7091</u>	<u>7462</u>	<u>7840</u>	<u>8213</u>	<u>8584</u>	<u>9135</u>	<u>9501</u>
<u>25</u>	<u>S</u>	<u>6609</u>	<u>6801</u>	<u>7170</u>	<u>7540</u>	<u>7915</u>	<u>8288</u>	<u>8659</u>	<u>9213</u>	<u>9582</u>
<u>26</u>	<u>B</u>	<u>6605</u>	<u>6866</u>	<u>7241</u>	<u>7626</u>	<u>8012</u>	<u>8385</u>	<u>8762</u>	<u>9328</u>	<u>9700</u>
<u>26</u>	<u>Q</u>	<u>6917</u>	<u>7196</u>	<u>7587</u>	<u>7989</u>	<u>8393</u>	<u>8785</u>	<u>9177</u>	<u>9772</u>	<u>10162</u>
<u>27</u>	<u>B</u>	<u>6979</u>	<u>7329</u>	<u>7728</u>	<u>8136</u>	<u>8548</u>	<u>8948</u>	<u>9350</u>	<u>9954</u>	<u>10353</u>

**Effective June 1, 2011**  
**Bargaining Unit: VR-704**

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>STEPS</u>								
		<u>1a</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
<u>23</u>	<u>Q</u>	<u>5937</u>	<u>6114</u>	<u>6440</u>	<u>6774</u>	<u>7101</u>	<u>7425</u>	<u>7762</u>	<u>8251</u>	<u>8580</u>
<u>23</u>	<u>S</u>	<u>6010</u>	<u>6190</u>	<u>6512</u>	<u>6849</u>	<u>7174</u>	<u>7503</u>	<u>7840</u>	<u>8324</u>	<u>8657</u>
<u>24</u>	<u>B</u>	<u>5977</u>	<u>6157</u>	<u>6484</u>	<u>6825</u>	<u>7150</u>	<u>7482</u>	<u>7818</u>	<u>8310</u>	<u>8641</u>
<u>24</u>	<u>Q</u>	<u>6249</u>	<u>6436</u>	<u>6779</u>	<u>7131</u>	<u>7475</u>	<u>7816</u>	<u>8171</u>	<u>8685</u>	<u>9032</u>
<u>24</u>	<u>S</u>	<u>6326</u>	<u>6516</u>	<u>6855</u>	<u>7209</u>	<u>7552</u>	<u>7898</u>	<u>8253</u>	<u>8762</u>	<u>9113</u>
<u>25</u>	<u>B</u>	<u>6371</u>	<u>6563</u>	<u>6921</u>	<u>7286</u>	<u>7650</u>	<u>8013</u>	<u>8378</u>	<u>8915</u>	<u>9273</u>
<u>25</u>	<u>Q</u>	<u>6656</u>	<u>6856</u>	<u>7233</u>	<u>7611</u>	<u>7997</u>	<u>8377</u>	<u>8756</u>	<u>9318</u>	<u>9691</u>
<u>25</u>	<u>S</u>	<u>6741</u>	<u>6937</u>	<u>7313</u>	<u>7691</u>	<u>8073</u>	<u>8454</u>	<u>8832</u>	<u>9397</u>	<u>9774</u>

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>26</u>	<u>B</u>	<u>6737</u>	<u>7003</u>	<u>7386</u>	<u>7779</u>	<u>8172</u>	<u>8553</u>	<u>8937</u>	<u>9515</u>	<u>9894</u>
<u>26</u>	<u>Q</u>	<u>7055</u>	<u>7340</u>	<u>7739</u>	<u>8149</u>	<u>8561</u>	<u>8961</u>	<u>9361</u>	<u>9967</u>	<u>10365</u>
<u>27</u>	<u>B</u>	<u>7119</u>	<u>7476</u>	<u>7883</u>	<u>8299</u>	<u>8719</u>	<u>9127</u>	<u>9537</u>	<u>10153</u>	<u>10560</u>

**Effective July 1, 2011**  
**Bargaining Unit: VR-704**

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>S T E P S</u>							
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
<u>23</u>	<u>Q</u>	<u>6358</u>	<u>6698</u>	<u>7045</u>	<u>7385</u>	<u>7723</u>	<u>8073</u>	<u>8580</u>	<u>8923</u>
<u>23</u>	<u>S</u>	<u>6438</u>	<u>6773</u>	<u>7122</u>	<u>7461</u>	<u>7803</u>	<u>8154</u>	<u>8656</u>	<u>9004</u>
<u>24</u>	<u>B</u>	<u>6403</u>	<u>6743</u>	<u>7098</u>	<u>7436</u>	<u>7781</u>	<u>8131</u>	<u>8642</u>	<u>8987</u>
<u>24</u>	<u>Q</u>	<u>6693</u>	<u>7050</u>	<u>7416</u>	<u>7774</u>	<u>8129</u>	<u>8498</u>	<u>9032</u>	<u>9393</u>
<u>24</u>	<u>S</u>	<u>6777</u>	<u>7129</u>	<u>7497</u>	<u>7854</u>	<u>8214</u>	<u>8583</u>	<u>9112</u>	<u>9478</u>
<u>25</u>	<u>B</u>	<u>6826</u>	<u>7198</u>	<u>7577</u>	<u>7956</u>	<u>8334</u>	<u>8713</u>	<u>9272</u>	<u>9644</u>
<u>25</u>	<u>Q</u>	<u>7130</u>	<u>7522</u>	<u>7915</u>	<u>8317</u>	<u>8712</u>	<u>9106</u>	<u>9691</u>	<u>10079</u>
<u>25</u>	<u>S</u>	<u>7214</u>	<u>7606</u>	<u>7999</u>	<u>8396</u>	<u>8792</u>	<u>9185</u>	<u>9773</u>	<u>10165</u>
<u>26</u>	<u>B</u>	<u>7283</u>	<u>7681</u>	<u>8090</u>	<u>8499</u>	<u>8895</u>	<u>9294</u>	<u>9896</u>	<u>10290</u>
<u>26</u>	<u>Q</u>	<u>7634</u>	<u>8049</u>	<u>8475</u>	<u>8903</u>	<u>9319</u>	<u>9735</u>	<u>10366</u>	<u>10780</u>
<u>27</u>	<u>B</u>	<u>7775</u>	<u>8198</u>	<u>8631</u>	<u>9068</u>	<u>9492</u>	<u>9918</u>	<u>10559</u>	<u>10982</u>

**Effective January 1, 2012**  
**Bargaining Unit: VR-704**

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>S T E P S</u>							
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
<u>23</u>	<u>Q</u>	<u>6438</u>	<u>6781</u>	<u>7134</u>	<u>7477</u>	<u>7819</u>	<u>8174</u>	<u>8688</u>	<u>9035</u>
<u>23</u>	<u>S</u>	<u>6519</u>	<u>6857</u>	<u>7211</u>	<u>7554</u>	<u>7901</u>	<u>8256</u>	<u>8765</u>	<u>9116</u>

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>24</u>	<u>B</u>	<u>6483</u>	<u>6827</u>	<u>7187</u>	<u>7529</u>	<u>7878</u>	<u>8233</u>	<u>8750</u>	<u>9099</u>
<u>24</u>	<u>Q</u>	<u>6777</u>	<u>7138</u>	<u>7509</u>	<u>7871</u>	<u>8231</u>	<u>8604</u>	<u>9145</u>	<u>9510</u>
<u>24</u>	<u>S</u>	<u>6862</u>	<u>7218</u>	<u>7591</u>	<u>7952</u>	<u>8317</u>	<u>8690</u>	<u>9226</u>	<u>9596</u>
<u>25</u>	<u>B</u>	<u>6911</u>	<u>7288</u>	<u>7672</u>	<u>8055</u>	<u>8438</u>	<u>8822</u>	<u>9388</u>	<u>9765</u>
<u>25</u>	<u>Q</u>	<u>7219</u>	<u>7616</u>	<u>8014</u>	<u>8421</u>	<u>8821</u>	<u>9220</u>	<u>9812</u>	<u>10205</u>
<u>25</u>	<u>S</u>	<u>7304</u>	<u>7701</u>	<u>8099</u>	<u>8501</u>	<u>8902</u>	<u>9300</u>	<u>9895</u>	<u>10292</u>
<u>26</u>	<u>B</u>	<u>7374</u>	<u>7777</u>	<u>8191</u>	<u>8605</u>	<u>9006</u>	<u>9410</u>	<u>10020</u>	<u>10419</u>
<u>26</u>	<u>Q</u>	<u>7729</u>	<u>8150</u>	<u>8581</u>	<u>9014</u>	<u>9435</u>	<u>9857</u>	<u>10496</u>	<u>10915</u>
<u>27</u>	<u>B</u>	<u>7872</u>	<u>8300</u>	<u>8739</u>	<u>9181</u>	<u>9611</u>	<u>10042</u>	<u>10691</u>	<u>11119</u>

**~~Effective July 1, 2011~~**  
**~~Bargaining Unit: VR-704~~**

<b>Pay Grade</b>	<b>Pay Plan Code</b>	<b>STEPS</b>							
		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>
24	B	6403	6743	7098	7436	7781	8131	8642	8987
24	Q	6693	7050	7416	7774	8129	8498	9032	9393
24	S	6777	7129	7497	7854	8214	8583	9112	9478
25	B	6826	7198	7577	7956	8334	8713	9272	9644
25	Q	7130	7522	7915	8317	8712	9106	9691	10079
25	S	7214	7606	7999	8396	8792	9185	9773	10165
26	B	7283	7681	8090	8499	8895	9294	9896	10290
26	Q	7634	8049	8475	8903	9319	9735	10366	10780

**~~Effective January 1, 2012~~**  
**~~Bargaining Unit: VR-704~~**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Pay Grade	Pay Plan Code	S T E P S							
		1	2	3	4	5	6	7	8
24	B	6483	6827	7187	7529	7878	8233	8750	9099
24	Q	6777	7138	7509	7871	8231	8604	9145	9510
24	S	6862	7218	7591	7952	8317	8690	9226	9596
25	B	6911	7288	7672	8055	8438	8822	9388	9765
25	Q	7219	7616	8014	8421	8821	9220	9812	10205
25	S	7304	7701	8099	8501	8902	9300	9895	10292
26	B	7374	7777	8191	8605	9006	9410	10020	10419
26	Q	7729	8150	8581	9014	9435	9857	10496	10915
27	B	7872	8300	8739	9181	9611	10042	10691	11119

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX A Negotiated Rates of Pay****Section 310.TABLE W RC-062 (Technical Employees, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Accountant	00130	RC-062	14
Accountant Advanced	00133	RC-062	16
Accountant Supervisor	00135	RC-062	18
Accounting and Fiscal Administration Career Trainee	00140	RC-062	12
Activity Therapist	00157	RC-062	15
Activity Therapist Coordinator	00160	RC-062	17
Activity Therapist Supervisor	00163	RC-062	20
Actuarial Assistant	00187	RC-062	16
Actuarial Examiner	00195	RC-062	16
Actuarial Examiner Trainee	00196	RC-062	13
Actuarial Senior Examiner	00197	RC-062	19
Actuary I	00201	RC-062	20
Actuary II	00202	RC-062	24
Agricultural Market News Assistant	00804	RC-062	12
Agricultural Marketing Generalist	00805	RC-062	14
Agricultural Marketing Reporter	00807	RC-062	18
Agricultural Marketing Representative	00810	RC-062	18
Agriculture Land and Water Resource Specialist I	00831	RC-062	14
Agriculture Land and Water Resource Specialist II	00832	RC-062	17
Agriculture Land and Water Resource Specialist III	00833	RC-062	20
Aircraft Pilot I	00955	RC-062	19
Aircraft Pilot II	00956	RC-062	22
Aircraft Pilot II – Dual Rating	00957	RC-062	23
Appraisal Specialist I	01251	RC-062	14
Appraisal Specialist II	01252	RC-062	16
Appraisal Specialist III	01253	RC-062	18
Arts Council Associate	01523	RC-062	12
Arts Council Program Coordinator	01526	RC-062	18
Arts Council Program Representative	01527	RC-062	15
Assignment Coordinator	01530	RC-062	20
Bank Examiner I	04131	RC-062	16
Bank Examiner II	04132	RC-062	19
Bank Examiner III	04133	RC-062	22

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Behavioral Analyst Associate	04355	RC-062	15
Behavioral Analyst I	04351	RC-062	17
Behavioral Analyst II	04352	RC-062	19
Business Administrative Specialist	05810	RC-062	16
Business Manager	05815	RC-062	18
Buyer	05900	RC-062	18
<u>Cancer Registrar I</u>	<u>05951</u>	<u>RC-062</u>	<u>14</u>
Cancer Registrar II	05952	RC-062	16
<u>Cancer Registrar III</u>	<u>05953</u>	<u>RC-062</u>	<u>20</u>
<u>Cancer Registrar Assistant Manager</u>	<u>05954</u>	<u>RC-062</u>	<u>22</u>
<u>Cancer Registrar Manager</u>	<u>05955</u>	<u>RC-062</u>	<u>24</u>
Capital Development Board Account Technician	06515	RC-062	11
Capital Development Board Art in Architecture Technician	06533	RC-062	12
Capital Development Board Construction Support Analyst	06520	RC-062	11
Capital Development Board Project Technician	06530	RC-062	12
Chemist I	06941	RC-062	16
Chemist II	06942	RC-062	19
Chemist III	06943	RC-062	21
Child Protection Advanced Specialist	07161	RC-062	19
Child Protection Associate Specialist	07162	RC-062	16
Child Protection Specialist	07163	RC-062	18
Child Support Specialist I	07198	RC-062	16
Child Support Specialist II	07199	RC-062	17
Child Support Specialist Trainee	07200	RC-062	12
Child Welfare Associate Specialist	07216	RC-062	16
Child Welfare Staff Development Coordinator I	07201	RC-062	17
Child Welfare Staff Development Coordinator II	07202	RC-062	19
Child Welfare Staff Development Coordinator III	07203	RC-062	20
Child Welfare Staff Development Coordinator IV	07204	RC-062	22
Children and Family Service Intern – Option I	07241	RC-062	12
Children and Family Service Intern – Option II	07242	RC-062	15
Clinical Laboratory Technologist I	08220	RC-062	18
Clinical Laboratory Technologist II	08221	RC-062	19
Clinical Laboratory Technologist Trainee	08229	RC-062	14
Communications Systems Specialist	08860	RC-062	23
Community Management Specialist I	08891	RC-062	15
Community Management Specialist II	08892	RC-062	17
Community Management Specialist III	08893	RC-062	19
Community Planner I	08901	RC-062	15

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Community Planner II	08902	RC-062	17
Community Planner III	08903	RC-062	19
Conservation Education Representative	09300	RC-062	12
Conservation Grant Administrator I	09311	RC-062	18
Conservation Grant Administrator II	09312	RC-062	20
Conservation Grant Administrator III	09313	RC-062	22
Construction Program Assistant	09525	RC-062	12
Correctional Counselor I	09661	RC-062	15
Correctional Counselor II	09662	RC-062	17
Correctional Counselor III	09663	RC-062	19
Corrections Apprehension Specialist	09750	RC-062	19
Corrections Industries Marketing Representative	09803	RC-062	17
Corrections Leisure Activities Specialist I	09811	RC-062	15
Corrections Leisure Activities Specialist II	09812	RC-062	17
Corrections Leisure Activities Specialist III	09813	RC-062	19
Corrections Parole Agent	09842	RC-062	17
Corrections Senior Parole Agent	09844	RC-062	19
Criminal Intelligence Analyst I	10161	RC-062	18
Criminal Intelligence Analyst II	10162	RC-062	20
Criminal Intelligence Analyst Specialist	10165	RC-062	22
Criminal Justice Specialist I	10231	RC-062	16
Criminal Justice Specialist II	10232	RC-062	20
Criminal Justice Specialist Trainee	10236	RC-062	13
Curator of the Lincoln Collection	10750	RC-062	16
Data Processing Supervisor I	11435	RC-062	11
Data Processing Supervisor II	11436	RC-062	14
Data Processing Supervisor III	11437	RC-062	18
Day Care Licensing Representative I	11471	RC-062	16
Developmental Disabilities Council Program Planner I	12361	RC-062	12
Developmental Disabilities Council Program Planner II	12362	RC-062	16
Developmental Disabilities Council Program Planner III	12363	RC-062	18
Dietary Manager I	12501	RC-062	16
Dietary Manager II	12502	RC-062	18
Dietitian	12510	RC-062	15
Disability Appeals Officer	12530	RC-062	22
Disability Claims Adjudicator I	12537	RC-062	16
Disability Claims Adjudicator II	12538	RC-062	18
Disability Claims Adjudicator Trainee	12539	RC-062	13
Disability Claims Analyst	12540	RC-062	21

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Disability Claims Specialist	12558	RC-062	19
Disaster Services Planner	12585	RC-062	19
Document Examiner	12640	RC-062	22
Economic Development Representative I	12931	RC-062	17
Economic Development Representative II	12932	RC-062	19
Educational Diagnostician	12965	RC-062	12
Educator – Provisional	13105	RC-062	12
Employment Security Field Office Supervisor	13600	RC-062	20
Employment Security Manpower Representative I	13621	RC-062	12
Employment Security Manpower Representative II	13622	RC-062	14
Employment Security Program Representative	13650	RC-062	14
Employment Security Program Representative – Intermittent	13651	RC-062	14H
Employment Security Service Representative	13667	RC-062	16
Employment Security Service Representative (Intermittent)	13667	RC-062	16H
Employment Security Specialist I	13671	RC-062	14
Employment Security Specialist II	13672	RC-062	16
Employment Security Specialist III	13673	RC-062	19
Employment Security Tax Auditor I	13681	RC-062	17
Employment Security Tax Auditor II	13682	RC-062	19
Energy and Natural Resources Specialist I	13711	RC-062	15
Energy and Natural Resources Specialist II	13712	RC-062	17
Energy and Natural Resources Specialist III	13713	RC-062	19
Energy and Natural Resources Specialist Trainee	13715	RC-062	12
Engineering Technician IV (Department of Public Health)	13734	RC-062	18
Environmental Health Specialist I	13768	RC-062	14
Environmental Health Specialist II	13769	RC-062	16
Environmental Health Specialist III	13770	RC-062	18
Environmental Protection Associate	13785	RC-062	12
Environmental Protection Specialist I	13821	RC-062	14
Environmental Protection Specialist II	13822	RC-062	16
Environmental Protection Specialist III	13823	RC-062	18
Environmental Protection Specialist IV	13824	RC-062	22
Equal Pay Specialist	13837	RC-062	17
Executive I	13851	RC-062	18
Executive II	13852	RC-062	20
Financial Institutions Examiner I	14971	RC-062	16
Financial Institutions Examiner II	14972	RC-062	19
Financial Institutions Examiner III	14973	RC-062	22
Financial Institutions Examiner Trainee	14978	RC-062	13

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Fire Protection Specialist I	15351	RC-062	16
Flight Safety Coordinator	15640	RC-062	22
Forensic Scientist I	15891	RC-062	18
Forensic Scientist II	15892	RC-062	20
Forensic Scientist III	15893	RC-062	22
Forensic Scientist Trainee	15897	RC-062	15
Gaming Licensing Analyst	17171	RC-062	13
Gaming Senior Special Agent	17191	RC-062	23
Gaming Special Agent	17192	RC-062	19
Gaming Special Agent Trainee	17195	RC-062	14
Guardianship Representative	17710	RC-062	17
Habilitation Program Coordinator	17960	RC-062	17
Handicapped Services Representative I	17981	RC-062	11
Health Facilities Surveyor I	18011	RC-062	16
Health Facilities Surveyor II	18012	RC-062	19
Health Facilities Surveyor III	18013	RC-062	20
Health Information Administrator	18041	RC-062	15
Health Services Investigator I – Opt. A	18181	RC-062	19
Health Services Investigator I – Opt. B	18182	RC-062	20
Health Services Investigator II – Opt. A	18185	RC-062	22
Health Services Investigator II – Opt. B	18186	RC-062	22
Health Services Investigator II – Opt. C	18187	RC-062	25
Health Services Investigator II – Opt. D	18188	RC-062	25
Historical Documents Conservator I	18981	RC-062	13
Historical Exhibits Designer	18985	RC-062	15
Historical Research Editor II	19002	RC-062	14
Human Relations Representative	19670	RC-062	16
Human Resources Representative	19692	RC-062	17
Human Resources Specialist	19693	RC-062	20
Human Rights Investigator I	19774	RC-062	16
Human Rights Investigator II	19775	RC-062	18
Human Rights Investigator III	19776	RC-062	19
Human Rights Mediator	19771	RC-062	17
Human Rights Specialist I	19778	RC-062	14
Human Rights Specialist II	19779	RC-062	16
Human Rights Specialist III	19780	RC-062	18
Human Services Casework Manager	19788	RC-062	20
Human Services Caseworker	19785	RC-062	16
Human Services Grants Coordinator I	19791	RC-062	14

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Human Services Grants Coordinator II	19792	RC-062	17
Human Services Grants Coordinator III	19793	RC-062	20
Human Services Grants Coordinator Trainee	19796	RC-062	12
Human Services Sign Language Interpreter	19810	RC-062	16
Iconographer	19880	RC-062	12
Industrial and Community Development Representative I	21051	RC-062	17
Industrial and Community Development Representative II	21052	RC-062	19
Industrial Services Consultant I	21121	RC-062	14
Industrial Services Consultant II	21122	RC-062	16
Industrial Services Consultant Trainee	21125	RC-062	11
Industrial Services Hygienist	21127	RC-062	19
Industrial Services Hygienist Technician	21130	RC-062	16
Industrial Services Hygienist Trainee	21133	RC-062	12
Information Technology/Communication Systems Specialist I	21216	RC-062	19
Information Technology/Communication Systems Specialist II	21217	RC-062	24
Instrument Designer	21500	RC-062	18
Insurance Analyst III	21563	RC-062	14
Insurance Analyst IV	21564	RC-062	16
Insurance Company Claims Examiner II	21602	RC-062	19
Insurance Company Field Staff Examiner	21608	RC-062	16
Insurance Company Financial Examiner Trainee	21610	RC-062	13
Insurance Performance Examiner I	21671	RC-062	14
Insurance Performance Examiner II	21672	RC-062	17
Insurance Performance Examiner III	21673	RC-062	20
Intermittent Unemployment Insurance Representative	21689	RC-062	12H
Internal Auditor I	21721	RC-062	17
Internal Security Investigator I, not Department of Corrections	21731	RC-062	18
Internal Security Investigator II, not Department of Corrections	21732	RC-062	21
International Marketing Representative I, Department of Agriculture	21761	RC-062	14
Juvenile Justice Youth and Family Specialist, Option 1	21991	RC-062	18
Juvenile Justice Youth and Family Specialist, Option 2	21992	RC-062	20
KidCare Supervisor	22003	RC-062	20
Labor Conciliator	22750	RC-062	20
Laboratory Equipment Specialist	22990	RC-062	18
Laboratory Quality Specialist I	23021	RC-062	19
Laboratory Quality Specialist II	23022	RC-062	21
Laboratory Research Specialist I	23027	RC-062	19
Laboratory Research Specialist II	23028	RC-062	21

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Land Acquisition Agent I	23091	RC-062	15
Land Acquisition Agent II	23092	RC-062	18
Land Acquisition Agent III	23093	RC-062	21
Land Reclamation Specialist I	23131	RC-062	14
Land Reclamation Specialist II	23132	RC-062	17
Liability Claims Adjuster I	23371	RC-062	14
Liability Claims Adjuster II	23372	RC-062	18
Library Associate	23430	RC-062	12
Life Sciences Career Trainee	23600	RC-062	12
Liquor Control Special Agent II	23752	RC-062	15
Local Historical Services Representative	24000	RC-062	17
Local Housing Advisor I	24031	RC-062	14
Local Housing Advisor II	24032	RC-062	16
Local Housing Advisor III	24033	RC-062	18
Local Revenue and Fiscal Advisor I	24101	RC-062	15
Local Revenue and Fiscal Advisor II	24102	RC-062	17
Local Revenue and Fiscal Advisor III	24103	RC-062	19
Lottery Regional Coordinator	24504	RC-062	19
Lottery Sales Representative	24515	RC-062	16
Management Operations Analyst I	25541	RC-062	18
Management Operations Analyst II	25542	RC-062	20
Manpower Planner I	25591	RC-062	14
Manpower Planner II	25592	RC-062	17
Manpower Planner III	25593	RC-062	20
Manpower Planner Trainee	25597	RC-062	12
Medical Assistance Consultant I	26501	RC-062	13
Medical Assistance Consultant II	26502	RC-062	16
Medical Assistance Consultant III	26503	RC-062	19
Mental Health Administrator I	26811	RC-062	18
Mental Health Administrator II	26812	RC-062	20
Mental Health Administrator Trainee	26817	RC-062	16
Mental Health Recovery Support Specialist I	26921	RC-062	17
Mental Health Recovery Support Specialist II	26922	RC-062	18
Mental Health Specialist I	26924	RC-062	12
Mental Health Specialist II	26925	RC-062	14
Mental Health Specialist III	26926	RC-062	16
Mental Health Specialist Trainee	26928	RC-062	11
Meteorologist	27120	RC-062	18
Methods and Procedures Advisor I	27131	RC-062	14

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Methods and Procedures Advisor II	27132	RC-062	16
Methods and Procedures Advisor III	27133	RC-062	20
Methods and Procedures Career Associate I	27135	RC-062	11
Methods and Procedures Career Associate II	27136	RC-062	12
Methods and Procedures Career Associate Trainee	27137	RC-062	09
Metrologist Associate	27146	RC-062	15
Microbiologist I	27151	RC-062	16
Microbiologist II	27152	RC-062	19
Natural Resources Advanced Specialist	28833	RC-062	20
Natural Resources Coordinator	28831	RC-062	15
Natural Resources Specialist	28832	RC-062	18
Oral Health Consultant	30317	RC-062	18
Paralegal Assistant	30860	RC-062	14
Pension and Death Benefits Technician I	30961	RC-062	12
Pension and Death Benefits Technician II	30962	RC-062	19
Plumbing Consultant (Department of Public Health)	32910	RC-062	22
Police Training Specialist	32990	RC-062	17
Program Integrity Auditor I	34631	RC-062	16
Program Integrity Auditor II	34632	RC-062	19
Program Integrity Auditor Trainee	34635	RC-062	12
Property Consultant	34900	RC-062	15
Public Aid Investigator	35870	RC-062	19
Public Aid Investigator Trainee	35874	RC-062	14
Public Aid Lead Casework Specialist	35880	RC-062	17
Public Aid Program Quality Analyst	35890	RC-062	19
Public Aid Quality Control Reviewer	35892	RC-062	17
Public Aid Quality Control Supervisor	35900	RC-062	19
Public Aid Staff Development Specialist I	36071	RC-062	15
Public Aid Staff Development Specialist II	36072	RC-062	17
Public Health Educator Associate	36434	RC-062	14
Public Health Program Specialist I	36611	RC-062	14
Public Health Program Specialist II	36612	RC-062	16
Public Health Program Specialist III	36613	RC-062	19
Public Health Program Specialist Trainee	36615	RC-062	12
Public Information Coordinator	36750	RC-062	18
Public Information Officer I	37001	RC-062	12
Public Information Officer II	37002	RC-062	14
Public Information Officer III	37003	RC-062	19
Public Information Officer IV	37004	RC-062	21

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Public Safety Inspector	37007	RC-062	16
Public Safety Inspector Trainee	37010	RC-062	10
Public Service Administrator, Option 8Z	37015	RC-062	19
Public Service Administrator, Options 2, 6, 7 Gaming Board and Departments of Healthcare and Family Services and Revenue, 8C, 8F executive chief pilot function Department of Transportation, 9A and 9B	37015	RC-062	24
Public Service Administrator, Options 8B and 8Y	37015	RC-062	23
Railroad Safety Specialist I	37601	RC-062	19
Railroad Safety Specialist II	37602	RC-062	21
Railroad Safety Specialist III	37603	RC-062	23
Railroad Safety Specialist IV	37604	RC-062	25
Real Estate Investigator	37730	RC-062	19
Real Estate Professions Examiner	37760	RC-062	22
Recreation Worker I	38001	RC-062	12
Recreation Worker II	38002	RC-062	14
Rehabilitation Counselor	38145	RC-062	17
Rehabilitation Counselor Senior	38158	RC-062	19
Rehabilitation Counselor Trainee	38159	RC-062	15
Rehabilitation Services Advisor I	38176	RC-062	20
Rehabilitation Workshop Supervisor I	38194	RC-062	12
Rehabilitation Workshop Supervisor II	38195	RC-062	14
Rehabilitation Workshop Supervisor III	38196	RC-062	16
Reimbursement Officer I	38199	RC-062	14
Reimbursement Officer II	38200	RC-062	16
Research Economist I	38207	RC-062	18
Research Scientist I	38231	RC-062	13
Research Scientist II	38232	RC-062	16
Research Scientist III	38233	RC-062	20
Residential Services Supervisor	38280	RC-062	15
Resource Planner I	38281	RC-062	17
Resource Planner II	38282	RC-062	19
Resource Planner III	38283	RC-062	22
Retirement System Disability Specialist	38310	RC-062	19
Revenue Audit Supervisor	38369	RC-062	25
Revenue Audit Supervisor (states other than IL and not assigned to RC-062-29 – Hired prior to April 1, 2013)	38369	RC-062	27
Revenue Audit Supervisor (See Note – Hired prior to April 1, 2013)	38369	RC-062	29

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Revenue Auditor I	38371	RC-062	16
Revenue Auditor I (states other than IL and not assigned to RC-062-21 – Hired prior to April 1, 2013)	38371	RC-062	19
Revenue Auditor I (See Note – Hired prior to April 1, 2013)	38371	RC-062	21
Revenue Auditor II	38372	RC-062	19
Revenue Auditor II (states other than IL and not assigned to RC-062-24 – Hired prior to April 1, 2013)	38372	RC-062	22
Revenue Auditor II (See Note – Hired prior to April 1, 2013)	38372	RC-062	24
Revenue Auditor III	38373	RC-062	22
Revenue Auditor III (states other than IL and not assigned to RC-062-26 – Hired prior to April 1, 2013)	38373	RC-062	24
Revenue Auditor III (See Note – Hired prior to April 1, 2013)	38373	RC-062	26
Revenue Auditor Trainee	38375	RC-062	12
Revenue Auditor Trainee (states other than IL and not assigned to RC-062-15 – Hired prior to April 1, 2013)	38375	RC-062	13
Revenue Auditor Trainee (See Note – Hired prior to April 1, 2013)	38375	RC-062	15
Revenue Collection Officer I	38401	RC-062	15
Revenue Collection Officer II	38402	RC-062	17
Revenue Collection Officer III	38403	RC-062	19
Revenue Collection Officer Trainee	38405	RC-062	12
Revenue Computer Audit Specialist	38425	RC-062	23
Revenue Computer Audit Specialist (states other than IL and not assigned to RC-062-27 – Hired prior to April 1, 2013)	38425	RC-062	25
Revenue Computer Audit Specialist (See Note – Hired prior to April 1, 2013)	38425	RC-062	27
Revenue Senior Special Agent	38557	RC-062	23
Revenue Special Agent	38558	RC-062	19
Revenue Special Agent Trainee	38565	RC-062	14
Revenue Tax Specialist I	38571	RC-062	12
Revenue Tax Specialist II (IL)	38572	RC-062	14
Revenue Tax Specialist II (states other than IL, CA or NJ)	38572	RC-062	17
Revenue Tax Specialist II (CA or NJ)	38572	RC-062	19
Revenue Tax Specialist III	38573	RC-062	17
Revenue Tax Specialist Trainee	38575	RC-062	10
Senior Public Service Administrator, Option 7 Gaming Board and Department of Revenue	40070	RC-062	26

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>Sex Offender Therapist I</u>	<u>40531</u>	<u>RC-062</u>	<u>17</u>
<u>Sex Offender Therapist II</u>	<u>40532</u>	<u>RC-062</u>	<u>19</u>
Site Assistant Superintendent I	41071	RC-062	15
Site Assistant Superintendent II	41072	RC-062	17
Site Interpretive Coordinator	41093	RC-062	13
Site Services Specialist I	41117	RC-062	15
Site Services Specialist II	41118	RC-062	17
Social Service Consultant I	41301	RC-062	18
Social Service Consultant II	41302	RC-062	19
Social Service Program Planner I	41311	RC-062	15
Social Service Program Planner II	41312	RC-062	17
Social Service Program Planner III	41313	RC-062	20
Social Service Program Planner IV	41314	RC-062	22
Social Services Career Trainee	41320	RC-062	12
Social Worker I	41411	RC-062	<u>1716</u>
Staff Development Specialist I	41771	RC-062	18
Staff Development Technician I	41781	RC-062	12
Staff Development Technician II	41782	RC-062	15
State Mine Inspector	42230	RC-062	19
State Police Field Specialist I	42001	RC-062	18
State Police Field Specialist II	42002	RC-062	20
Statistical Research Specialist I	42741	RC-062	12
Statistical Research Specialist II	42742	RC-062	14
Statistical Research Specialist III	42743	RC-062	17
Storage Tank Safety Specialist	43005	RC-062	18
Telecommunications Specialist	45295	RC-062	15
Telecommunications Systems Analyst	45308	RC-062	17
Telecommunications Systems Technician I	45312	RC-062	10
Telecommunications Systems Technician II	45313	RC-062	13
Terrorism Research Specialist I	45371	RC-062	18
Terrorism Research Specialist II	45372	RC-062	20
Terrorism Research Specialist III	45373	RC-062	22
Terrorism Research Specialist Trainee	45375	RC-062	14
Unemployment Insurance Adjudicator I	47001	RC-062	11
Unemployment Insurance Adjudicator II	47002	RC-062	13
Unemployment Insurance Adjudicator III	47003	RC-062	15
Unemployment Insurance Revenue Analyst I	47081	RC-062	15
Unemployment Insurance Revenue Analyst II	47082	RC-062	17
Unemployment Insurance Revenue Specialist	47087	RC-062	13

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Unemployment Insurance Special Agent	47096	RC-062	18
Vehicle Emission Compliance Supervisor, Environmental Protection Agency	47583	RC-062	15
Veterans Educational Specialist I	47681	RC-062	15
Veterans Educational Specialist II	47682	RC-062	17
Veterans Educational Specialist III	47683	RC-062	21
Veterans Employment Representative I	47701	RC-062	14
Veterans Employment Representative II	47702	RC-062	16
Volunteer Services Coordinator I	48481	RC-062	13
Volunteer Services Coordinator II	48482	RC-062	16
Volunteer Services Coordinator III	48483	RC-062	18
Wage Claims Specialist	48770	RC-062	09
Weatherization Specialist I	49101	RC-062	14
Weatherization Specialist II	49102	RC-062	17
Weatherization Specialist III	49103	RC-062	20
Weatherization Specialist Trainee	49105	RC-062	12
Workers Compensation Insurance Compliance Investigator	49640	RC-062	20

NOTE: The positions allocated to the Public Service Administrator title that are assigned to a negotiated RC-062 pay grade have the following Options: 2; 6; 7; 8B; 8C; 8F; 8Y; 8Z; 9A; and 9B. The positions allocated to the Senior Public Service Administrator title that are assigned to a negotiated RC-062 pay grade have the Option 7. See the definition of option in Section 310.50.

Effective July 1, 2013, the Step 8 rate shall be increased by \$25.00 per month to \$75.00 a month for those employees who attain ten (10) years of continuous service and have three (3) or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2013. For those employees who attain fifteen (15) years of continuous service and have three (3) or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2013, the Step 8 rate shall be increased by \$25.00 per month to \$100.00 a month. Employees whose salaries are red-circled above the maximum Step rate continue to receive all applicable general increases and any other adjustments (except the longevity pay) provided for in the Agreement. For these employees, the longevity pay shall be limited to the amount that would increase the employee's salary to the amount that is equal to that of an employee on the maximum Step rate with the same number of years of continuous and creditable service. Employees receiving the longevity pay shall continue to receive the longevity pay as long as they remain in the same or successor classification as a result of a reclassification or reevaluation. Employees who are eligible for the increase provided

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

for longevity pay on or before January 1, 2002, shall continue to receive longevity pay after being placed on Step 8 while they remain in the same or lower pay grade.

For the Revenue Tax Specialist II position classification title only – The pay grade assigned to the employee is based on the location of the position and the residence held by the employee. In the same position classification, the employee holding a position and residence outside the boundaries of the State of Illinois is assigned to a different pay grade than the pay grade assigned to the employee holding a position within the boundaries of the State of Illinois. The pay grade assigned to the employee holding a position located within the boundaries of the State of Illinois is the pay grade with the (IL) indication next to the position classification. The pay grade assigned to the employee holding the position located outside the boundaries of the State of Illinois is determined by the location of the employee's residence or position location (e.g., IL, CA or NJ or a state other than IL, CA or NJ). If the employee's residence moves to another state while the employee is in the same position located outside the boundaries of the State of Illinois, or moves into another position located outside the boundaries of the State of Illinois in the same position classification, the base salary may change depending on the location of the employee's new residence. In all cases, change in base salary shall be on a step for step basis (e.g., if the original base salary was on Step 5 in one pay grade, the new base salary will also be on Step 5 of the newly appropriate pay grade).

For the Revenue Audit Supervisor, Revenue Auditor I, II and III, Revenue Auditor Trainee, and Revenue Computer Audit Specialist position classification titles only – Effective July 1, 2010, State employees appointed to positions allocated to the Revenue Audit Supervisor, Revenue Auditor I, II and III, Revenue Auditor Trainee, and Revenue Computer Audit Specialist classifications shall be assigned to the pay grades:

Revenue Audit Supervisor, RC-062-29  
Revenue Auditor I, RC-062-21  
Revenue Auditor II, RC-062-24  
Revenue Auditor III, RC-062-26  
Revenue Auditor Trainee, RC-062-25  
Revenue Computer Audit Specialist, RC-062-27

if the employee lives in California, 50% or more of the employee's work is within a 200 mile radius of the Paramus NJ Illinois Department of Revenue office, or 50% or more of the employee's work is within the District of Columbia.

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Effective July 1, 2012**  
**Bargaining Unit: RC-062**

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>S T E P S</u>							
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
09	B	3198	3297	3402	3507	3620	3726	3903	4059
09	Q	3327	3429	3540	3649	3768	3880	4066	4230
09	S	3396	3500	3613	3724	3844	3956	4143	4310
10	B	3300	3421	3522	3638	3753	3869	4067	4231
10	Q	3433	3558	3666	3791	3909	4032	4246	4416
10	S	3504	3629	3740	3864	3983	4114	4325	4497
11	B	3422	3538	3652	3785	3909	4031	4244	4414
11	Q	3560	3687	3807	3943	4075	4203	4431	4607
11	S	3630	3758	3879	4019	4151	4283	4510	4689
12	B	3560	3691	3811	3954	4083	4234	4461	4638
12	Q	3706	3843	3970	4123	4263	4417	4658	4845
12	S	3778	3916	4044	4201	4344	4499	4741	4932
12H	B	21.91	22.71	23.45	24.33	25.13	26.06	27.45	28.54
12H	Q	22.81	23.65	24.43	25.37	26.23	27.18	28.66	29.82
12H	S	23.25	24.10	24.89	25.85	26.73	27.69	29.18	30.35
13	B	3694	3829	3975	4124	4274	4435	4681	4867
13	Q	3847	3987	4144	4307	4465	4629	4892	5088
13	S	3920	4065	4225	4389	4543	4712	4976	5175
14	B	3852	3997	4153	4336	4493	4664	4937	5134
14	Q	4016	4168	4339	4526	4696	4876	5159	5364
14	S	4090	4250	4416	4607	4779	4959	5241	5448
14H	B	23.70	24.60	25.56	26.68	27.65	28.70	30.38	31.59

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

14H	Q	24.71	25.65	26.70	27.85	28.90	30.01	31.75	33.01
14H	S	25.17	26.15	27.18	28.35	29.41	30.52	32.25	33.53
15	B	4005	4182	4354	4524	4708	4884	5178	5383
15	Q	4179	4362	4543	4727	4923	5104	5408	5626
15	S	4256	4443	4624	4810	5006	5186	5493	5712
16	B	4192	4379	4574	4762	4962	5160	5465	5683
16	Q	4374	4574	4781	4980	5185	5392	5713	5944
16	S	4458	4655	4864	5065	5268	5477	5793	6024
16H	B	25.80	26.95	28.15	29.30	30.54	31.75	33.63	34.97
16H	Q	26.92	28.15	29.42	30.65	31.91	33.18	35.16	36.58
16H	S	27.43	28.65	29.93	31.17	32.42	33.70	35.65	37.07
17	B	4392	4594	4805	5010	5213	5424	5747	5976
17	Q	4582	4802	5024	5232	5445	5669	6005	6248
17	S	4665	4887	5108	5319	5529	5750	6093	6335
18	B	4623	4845	5070	5302	5517	5739	6080	6325
18	Q	4828	5067	5301	5542	5768	5998	6358	6611
18	S	4908	5147	5383	5625	5852	6084	6437	6696
19	B	4871	5119	5361	5608	5847	6090	6461	6719
19	J	4871	5119	5361	5608	5847	6090	6461	6719
19	Q	5091	5352	5599	5866	6110	6367	6750	7021
19	S	5177	5436	5685	5949	6195	6450	6833	7106
20	B	5146	5407	5657	5927	6185	6441	6832	7105
20	Q	5378	5649	5916	6197	6463	6731	7143	7428
20	S	5464	5733	5998	6278	6545	6815	7223	7512
21	B	5435	5715	5991	6270	6555	6829	7255	7544
21	U	5435	5715	5991	6270	6555	6829	7255	7544
21	Q	5680	5973	6260	6552	6852	7139	7582	7885
21	S	5764	6054	6341	6638	6935	7220	7666	7971

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

22	B	5746	6046	6339	6640	6947	7236	7687	7995
22	Q	6003	6318	6628	6938	7259	7565	8033	8352
22	S	6090	6397	6711	7021	7344	7651	8117	8442
23	B	6095	6418	6747	7067	7391	7712	8200	8528
23	Q	6373	6709	7052	7383	7727	8062	8566	8908
23	S	6455	6790	7135	7468	7809	8145	8651	8994
24	B	6487	6831	7191	7533	7883	8237	8755	9104
24	J	6487	6831	7191	7533	7883	8237	8755	9104
24	Q	6780	7142	7513	7875	8234	8608	9149	9516
24	S	6865	7222	7594	7956	8321	8693	9231	9600
25	B	6915	7291	7677	8060	8442	8827	9393	9769
25	J	6915	7291	7677	8060	8442	8827	9393	9769
25	Q	7223	7620	8018	8425	8826	9225	9816	10210
25	S	7308	7703	8103	8505	8906	9305	9899	10298
26	B	7377	7782	8196	8609	9011	9416	10023	10423
26	U	7377	7782	8196	8609	9011	9416	10023	10423
26	Q	7734	8153	8584	9018	9440	9861	10500	10920
26	S	7805	8230	8668	9105	9529	9957	10604	11027
27	B	7876	8306	8743	9185	9617	10049	10697	11126
27	J	7876	8306	8743	9185	9617	10049	10697	11126
27	U	7876	8306	8743	9185	9617	10049	10697	11126
27	Q	8232	8680	9137	9604	10053	10504	11182	11630
28	B	8264	8711	9174	9639	10091	10543	11225	11676
29	U	8672	9143	9627	10115	10589	11064	11780	12250

**Effective May 20, 2013**  
**Bargaining Unit: RC-062**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>S T E P S</u>										
		<u>1c</u>	<u>1b</u>	<u>1a</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
9	B	2910	3006	3102	3198	3297	3402	3507	3620	3726	3903	4059
9	Q	3028	3127	3227	3327	3429	3540	3649	3768	3880	4066	4230
9	S	3090	3192	3294	3396	3500	3613	3724	3844	3956	4143	4310
10	B	3003	3102	3201	3300	3421	3522	3638	3753	3869	4067	4231
10	Q	3124	3227	3330	3433	3558	3666	3791	3909	4032	4246	4416
10	S	3189	3294	3399	3504	3629	3740	3864	3983	4114	4325	4497
11	B	3114	3217	3319	3422	3538	3652	3785	3909	4031	4244	4414
11	Q	3240	3346	3453	3560	3687	3807	3943	4075	4203	4431	4607
11	S	3303	3412	3521	3630	3758	3879	4019	4151	4283	4510	4689
12	B	3240	3346	3453	3560	3691	3811	3954	4083	4234	4461	4638
12	Q	3372	3484	3595	3706	3843	3970	4123	4263	4417	4658	4845
12	S	3438	3551	3665	3778	3916	4044	4201	4344	4499	4741	4932
12H	B	19.94	20.59	21.25	21.91	22.71	23.45	24.33	25.13	26.06	27.45	28.54
12H	Q	20.75	21.44	22.12	22.81	23.65	24.43	25.37	26.23	27.18	28.66	29.82
12H	S	21.16	21.85	22.55	23.25	24.10	24.89	25.85	26.73	27.69	29.18	30.35
13	B	3362	3472	3583	3694	3829	3975	4124	4274	4435	4681	4867
13	Q	3501	3616	3732	3847	3987	4144	4307	4465	4629	4892	5088
13	S	3567	3685	3802	3920	4065	4225	4389	4543	4712	4976	5175
14	B	3505	3621	3736	3852	3997	4153	4336	4493	4664	4937	5134
14	Q	3655	3775	3896	4016	4168	4339	4526	4696	4876	5159	5364
14	S	3722	3845	3967	4090	4250	4416	4607	4779	4959	5241	5448
14H	B	21.57	22.28	22.99	23.70	24.60	25.56	26.68	27.65	28.70	30.38	31.59
14H	Q	22.49	23.23	23.98	24.71	25.65	26.70	27.85	28.90	30.01	31.75	33.01
14H	S	22.90	23.66	24.41	25.17	26.15	27.18	28.35	29.41	30.52	32.25	33.53

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

15	B	3645	3765	3885	4005	4182	4354	4524	4708	4884	5178	5383
15	Q	3803	3928	4054	4179	4362	4543	4727	4923	5104	5408	5626
15	S	3873	4001	4128	4256	4443	4624	4810	5006	5186	5493	5712
16	B	3815	3940	4066	4192	4379	4574	4762	4962	5160	5465	5683
16	Q	3980	4112	4243	4374	4574	4781	4980	5185	5392	5713	5944
16	S	4057	4191	4324	4458	4655	4864	5065	5268	5477	5793	6024
16H	B	23.48	24.25	25.02	25.80	26.95	28.15	29.30	30.54	31.75	33.63	34.97
16H	Q	24.49	25.30	26.11	26.92	28.15	29.42	30.65	31.91	33.18	35.16	36.58
16H	S	24.97	25.79	26.61	27.43	28.65	29.93	31.17	32.42	33.70	35.65	37.07
17	B	3997	4128	4260	4392	4594	4805	5010	5213	5424	5747	5976
17	Q	4170	4307	4445	4582	4802	5024	5232	5445	5669	6005	6248
17	S	4245	4385	4525	4665	4887	5108	5319	5529	5750	6093	6335
18	B	4207	4346	4484	4623	4845	5070	5302	5517	5739	6080	6325
18	Q	4393	4538	4683	4828	5067	5301	5542	5768	5998	6358	6611
18	S	4466	4614	4761	4908	5147	5383	5625	5852	6084	6437	6696
19	B	4433	4579	4725	4871	5119	5361	5608	5847	6090	6461	6719
19	J	4433	4579	4725	4871	5119	5361	5608	5847	6090	6461	6719
19	Q	4633	4786	4938	5091	5352	5599	5866	6110	6367	6750	7021
19	S	4711	4866	5022	5177	5436	5685	5949	6195	6450	6833	7106
20	B	4683	4837	4992	5146	5407	5657	5927	6185	6441	6832	7105
20	Q	4894	5055	5217	5378	5649	5916	6197	6463	6731	7143	7428
20	S	4972	5136	5300	5464	5733	5998	6278	6545	6815	7223	7512
21	B	4946	5109	5272	5435	5715	5991	6270	6555	6829	7255	7544
21	U	4946	5109	5272	5435	5715	5991	6270	6555	6829	7255	7544
21	Q	5169	5339	5510	5680	5973	6260	6552	6852	7139	7582	7885
21	S	5245	5418	5591	5764	6054	6341	6638	6935	7220	7666	7971
22	B	5229	5401	5574	5746	6046	6339	6640	6947	7236	7687	7995

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

22	Q	5463	5643	5823	6003	6318	6628	6938	7259	7565	8033	8352
22	S	5542	5725	5907	6090	6397	6711	7021	7344	7651	8117	8442
23	B	5546	5729	5912	6095	6418	6747	7067	7391	7712	8200	8528
23	Q	5799	5991	6182	6373	6709	7052	7383	7727	8062	8566	8908
23	S	5874	6068	6261	6455	6790	7135	7468	7809	8145	8651	8994
24	B	5903	6098	6292	6487	6831	7191	7533	7883	8237	8755	9104
24	J	5903	6098	6292	6487	6831	7191	7533	7883	8237	8755	9104
24	Q	6170	6373	6577	6780	7142	7513	7875	8234	8608	9149	9516
24	S	6247	6453	6659	6865	7222	7594	7956	8321	8693	9231	9600
25	B	6293	6500	6708	6915	7291	7677	8060	8442	8827	9393	9769
25	J	6293	6500	6708	6915	7291	7677	8060	8442	8827	9393	9769
25	Q	6573	6790	7006	7223	7620	8018	8425	8826	9225	9816	10210
25	S	6650	6870	7089	7308	7703	8103	8505	8906	9305	9899	10298
26	B	6713	6934	7156	7377	7782	8196	8609	9011	9416	10023	10423
26	U	6713	6934	7156	7377	7782	8196	8609	9011	9416	10023	10423
26	Q	7038	7270	7502	7734	8153	8584	9018	9440	9861	10500	10920
26	S	7103	7337	7571	7805	8230	8668	9105	9529	9957	10604	11027
27	B	7167	7403	7640	7876	8306	8743	9185	9617	10049	10697	11126
27	J	7167	7403	7640	7876	8306	8743	9185	9617	10049	10697	11126
27	U	7167	7403	7640	7876	8306	8743	9185	9617	10049	10697	11126
27	Q	7491	7738	7985	8232	8680	9137	9604	10053	10504	11182	11630
28	B	7520	7768	8016	8264	8711	9174	9639	10091	10543	11225	11676
29	U	7892	8152	8412	8672	9143	9627	10115	10589	11064	11780	12250

**Effective July 1, 2013**  
**Bargaining Unit: RC-062**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>S T E P S</u>										
		<u>1c</u>	<u>1b</u>	<u>1a</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
9	B	2968	3066	3164	3262	3363	3470	3577	3692	3801	3981	4140
9	Q	3089	3190	3292	3394	3498	3611	3722	3843	3958	4147	4315
9	S	3152	3256	3360	3464	3570	3685	3798	3921	4035	4226	4396
10	B	3063	3164	3265	3366	3489	3592	3711	3828	3946	4148	4316
10	Q	3186	3292	3397	3502	3629	3739	3867	3987	4113	4331	4504
10	S	3253	3360	3467	3574	3702	3815	3941	4063	4196	4412	4587
11	B	3176	3281	3385	3490	3609	3725	3861	3987	4112	4329	4502
11	Q	3305	3413	3522	3631	3761	3883	4022	4157	4287	4520	4699
11	S	3369	3480	3591	3703	3833	3957	4099	4234	4369	4600	4783
12	B	3305	3413	3522	3631	3765	3887	4033	4165	4319	4550	4731
12	Q	3439	3554	3667	3780	3920	4049	4205	4348	4505	4751	4942
12	S	3507	3622	3738	3854	3994	4125	4285	4431	4589	4836	5031
12H	B	20.34	21.00	21.67	22.34	23.17	23.92	24.82	25.63	26.58	28.00	29.11
12H	Q	21.16	21.87	22.57	23.26	24.12	24.92	25.88	26.76	27.72	29.24	30.41
12H	S	21.58	22.29	23.00	23.72	24.58	25.38	26.37	27.27	28.24	29.76	30.96
13	B	3429	3541	3655	3768	3906	4055	4206	4359	4524	4775	4964
13	Q	3571	3688	3807	3924	4067	4227	4393	4554	4722	4990	5190
13	S	3638	3759	3878	3998	4146	4310	4477	4634	4806	5076	5279
14	B	3575	3693	3811	3929	4077	4236	4423	4583	4757	5036	5237
14	Q	3728	3851	3974	4096	4251	4426	4617	4790	4974	5262	5471
14	S	3796	3922	4046	4172	4335	4504	4699	4875	5058	5346	5557
14H	B	22.00	22.73	23.45	24.18	25.09	26.07	27.22	28.20	29.27	30.99	32.23
14H	Q	22.94	23.70	24.46	25.21	26.16	27.24	28.41	29.48	30.61	32.38	33.67
14H	S	23.36	24.14	24.90	25.67	26.68	27.72	28.92	30.00	31.13	32.90	34.20

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

15	B	3718	3840	3963	4085	4266	4441	4614	4802	4982	5282	5491
15	Q	3879	4007	4135	4263	4449	4634	4822	5021	5206	5516	5739
15	S	3950	4081	4211	4341	4532	4716	4906	5106	5290	5603	5826
16	B	3891	4019	4147	4276	4467	4665	4857	5061	5263	5574	5797
16	Q	4060	4194	4328	4461	4665	4877	5080	5289	5500	5827	6063
16	S	4138	4275	4410	4547	4748	4961	5166	5373	5587	5909	6144
16H	B	23.94	24.73	25.52	26.31	27.49	28.71	29.89	31.14	32.39	34.30	35.67
16H	Q	24.98	25.81	26.63	27.45	28.71	30.01	31.26	32.55	33.85	35.86	37.31
16H	S	25.46	26.31	27.14	27.98	29.22	30.53	31.79	33.06	34.38	36.36	37.81
17	B	4077	4211	4345	4480	4686	4901	5110	5317	5532	5862	6096
17	Q	4253	4393	4534	4674	4898	5124	5337	5554	5782	6125	6373
17	S	4330	4473	4616	4758	4985	5210	5425	5640	5865	6215	6462
18	B	4291	4433	4574	4715	4942	5171	5408	5627	5854	6202	6452
18	Q	4481	4629	4777	4925	5168	5407	5653	5883	6118	6485	6743
18	S	4555	4706	4856	5006	5250	5491	5738	5969	6206	6566	6830
19	B	4522	4671	4820	4968	5221	5468	5720	5964	6212	6590	6853
19	J	4522	4671	4820	4968	5221	5468	5720	5964	6212	6590	6853
19	Q	4726	4882	5037	5193	5459	5711	5983	6232	6494	6885	7161
19	S	4805	4963	5122	5281	5545	5799	6068	6319	6579	6970	7248
20	B	4777	4934	5092	5249	5515	5770	6046	6309	6570	6969	7247
20	Q	4992	5156	5321	5486	5762	6034	6321	6592	6866	7286	7577
20	S	5071	5239	5406	5573	5848	6118	6404	6676	6951	7367	7662
21	B	5045	5211	5377	5544	5829	6111	6395	6686	6966	7400	7695
21	U	5045	5211	5377	5544	5829	6111	6395	6686	6966	7400	7695
21	Q	5272	5446	5620	5794	6092	6385	6683	6989	7282	7734	8043
21	S	5350	5526	5703	5879	6175	6468	6771	7074	7364	7819	8130
22	B	5334	5509	5685	5861	6167	6466	6773	7086	7381	7841	8155

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

22	Q	5572	5756	5939	6123	6444	6761	7077	7404	7716	8194	8519
22	S	5653	5840	6025	6212	6525	6845	7161	7491	7804	8279	8611
23	B	5657	5844	6030	6217	6546	6882	7208	7539	7866	8364	8699
23	Q	5915	6111	6306	6500	6843	7193	7531	7882	8223	8737	9086
23	S	5991	6189	6386	6584	6926	7278	7617	7965	8308	8824	9174
24	B	6021	6220	6418	6617	6968	7335	7684	8041	8402	8930	9286
24	J	6021	6220	6418	6617	6968	7335	7684	8041	8402	8930	9286
24	Q	6293	6500	6709	6916	7285	7663	8033	8399	8780	9332	9706
24	S	6372	6582	6792	7002	7366	7746	8115	8487	8867	9416	9792
25	B	6419	6630	6842	7053	7437	7831	8221	8611	9004	9581	9964
25	J	6419	6630	6842	7053	7437	7831	8221	8611	9004	9581	9964
25	Q	6704	6926	7146	7367	7772	8178	8594	9003	9410	10012	10414
25	S	6783	7007	7231	7454	7857	8265	8675	9084	9491	10097	10504
26	B	6847	7073	7299	7525	7938	8360	8781	9191	9604	10223	10631
26	U	6847	7073	7299	7525	7938	8360	8781	9191	9604	10223	10631
26	Q	7179	7415	7652	7889	8316	8756	9198	9629	10058	10710	11138
26	S	7245	7484	7722	7961	8395	8841	9287	9720	10156	10816	11248
27	B	7310	7551	7793	8034	8472	8918	9369	9809	10250	10911	11349
27	J	7310	7551	7793	8034	8472	8918	9369	9809	10250	10911	11349
27	U	7310	7551	7793	8034	8472	8918	9369	9809	10250	10911	11349
27	Q	7641	7893	8145	8397	8854	9320	9796	10254	10714	11406	11863
28	B	7670	7923	8176	8429	8885	9357	9832	10293	10754	11450	11910
29	U	8050	8315	8580	8845	9326	9820	10317	10801	11285	12016	12495

**Effective July 1, 2014**  
**Bargaining Unit: RC-062**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Pay Grade	Pay Plan Code	S T E P S										
		<u>1c</u>	<u>1b</u>	<u>1a</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
9	B	3027	3127	3227	3327	3430	3539	3649	3766	3877	4061	4223
9	Q	3151	3254	3358	3462	3568	3683	3796	3920	4037	4230	4401
9	S	3215	3321	3427	3533	3641	3759	3874	3999	4116	4311	4484
10	B	3124	3227	3330	3433	3559	3664	3785	3905	4025	4231	4402
10	Q	3250	3358	3465	3572	3702	3814	3944	4067	4195	4418	4594
10	S	3318	3427	3536	3645	3776	3891	4020	4144	4280	4500	4679
11	B	3240	3347	3453	3560	3681	3800	3938	4067	4194	4416	4592
11	Q	3371	3481	3592	3704	3836	3961	4102	4240	4373	4610	4793
11	S	3436	3550	3663	3777	3910	4036	4181	4319	4456	4692	4879
12	B	3371	3481	3592	3704	3840	3965	4114	4248	4405	4641	4826
12	Q	3508	3625	3740	3856	3998	4130	4289	4435	4595	4846	5041
12	S	3577	3694	3813	3931	4074	4208	4371	4520	4681	4933	5132
12H	B	20.74	21.42	22.10	22.79	23.63	24.40	25.32	26.14	27.11	28.56	29.70
12H	Q	21.59	22.31	23.02	23.73	24.60	25.42	26.39	27.29	28.28	29.82	31.02
12H	S	22.01	22.73	23.46	24.19	25.07	25.90	26.90	27.82	28.81	30.36	31.58
13	B	3498	3612	3728	3843	3984	4136	4290	4446	4614	4871	5063
13	Q	3642	3762	3883	4002	4148	4312	4481	4645	4816	5090	5294
13	S	3711	3834	3956	4078	4229	4396	4567	4727	4902	5178	5385
14	B	3647	3767	3887	4008	4159	4321	4511	4675	4852	5137	5342
14	Q	3803	3928	4053	4178	4336	4515	4709	4886	5073	5367	5580
14	S	3872	4000	4127	4255	4422	4594	4793	4973	5159	5453	5668
14H	B	22.44	23.18	23.92	24.66	25.59	26.59	27.76	28.77	29.86	31.61	32.87
14H	Q	23.40	24.17	24.94	25.71	26.68	27.78	28.98	30.07	31.22	33.03	34.34
14H	S	23.83	24.62	25.40	26.18	27.21	28.27	29.50	30.60	31.75	33.56	34.88

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

15	B	3792	3917	4042	4167	4351	4530	4706	4898	5082	5388	5601
15	Q	3957	4087	4218	4348	4538	4727	4918	5121	5310	5626	5854
15	S	4029	4163	4295	4428	4623	4810	5004	5208	5396	5715	5943
16	B	3969	4099	4230	4362	4556	4758	4954	5162	5368	5685	5913
16	Q	4141	4278	4415	4550	4758	4975	5182	5395	5610	5944	6184
16	S	4221	4361	4498	4638	4843	5060	5269	5480	5699	6027	6267
16H	B	24.42	25.22	26.03	26.84	28.04	29.28	30.49	31.77	33.03	34.98	36.39
16H	Q	25.48	26.33	27.17	28.00	29.28	30.62	31.89	33.20	34.52	36.58	38.06
16H	S	25.98	26.84	27.68	28.54	29.80	31.14	32.42	33.72	35.07	37.09	38.57
17	B	4159	4295	4432	4570	4780	4999	5212	5423	5643	5979	6218
17	Q	4338	4481	4625	4767	4996	5226	5444	5665	5898	6248	6500
17	S	4417	4562	4708	4853	5085	5314	5534	5753	5982	6339	6591
18	B	4377	4522	4665	4809	5041	5274	5516	5740	5971	6326	6581
18	Q	4571	4722	4873	5024	5271	5515	5766	6001	6240	6615	6878
18	S	4646	4800	4953	5106	5355	5601	5853	6088	6330	6697	6967
19	B	4612	4764	4916	5067	5325	5577	5834	6083	6336	6722	6990
19	J	4612	4764	4916	5067	5325	5577	5834	6083	6336	6722	6990
19	Q	4821	4980	5138	5297	5568	5825	6103	6357	6624	7023	7304
19	S	4901	5062	5224	5387	5656	5915	6189	6445	6711	7109	7393
20	B	4873	5033	5194	5354	5625	5885	6167	6435	6701	7108	7392
20	Q	5092	5259	5427	5596	5877	6155	6447	6724	7003	7432	7729
20	S	5172	5344	5514	5684	5965	6240	6532	6810	7090	7514	7815
21	B	5146	5315	5485	5655	5946	6233	6523	6820	7105	7548	7849
21	U	5146	5315	5485	5655	5946	6233	6523	6820	7105	7548	7849
21	Q	5377	5555	5732	5910	6214	6513	6817	7129	7428	7889	8204
21	S	5457	5637	5817	5997	6299	6597	6906	7215	7511	7975	8293
22	B	5441	5619	5799	5978	6290	6595	6908	7228	7529	7998	8318

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

22	Q	5683	5871	6058	6245	6573	6896	7219	7552	7870	8358	8689
22	S	5766	5957	6146	6336	6656	6982	7304	7641	7960	8445	8783
23	B	5770	5961	6151	6341	6677	7020	7352	7690	8023	8531	8873
23	Q	6033	6233	6432	6630	6980	7337	7682	8040	8387	8912	9268
23	S	6111	6313	6514	6716	7065	7424	7769	8124	8474	9000	9357
24	B	6141	6344	6546	6749	7107	7482	7838	8202	8570	9109	9472
24	J	6141	6344	6546	6749	7107	7482	7838	8202	8570	9109	9472
24	Q	6419	6630	6843	7054	7431	7816	8194	8567	8956	9519	9900
24	S	6499	6714	6928	7142	7513	7901	8277	8657	9044	9604	9988
25	B	6547	6763	6979	7194	7586	7988	8385	8783	9184	9773	10163
25	J	6547	6763	6979	7194	7586	7988	8385	8783	9184	9773	10163
25	Q	6838	7065	7289	7514	7927	8342	8766	9183	9598	10212	10622
25	S	6919	7147	7376	7603	8014	8430	8849	9266	9681	10299	10714
26	B	6984	7214	7445	7676	8097	8527	8957	9375	9796	10427	10844
26	U	6984	7214	7445	7676	8097	8527	8957	9375	9796	10427	10844
26	Q	7323	7563	7805	8047	8482	8931	9382	9822	10259	10924	11361
26	S	7390	7634	7876	8120	8563	9018	9473	9914	10359	11032	11473
27	B	7456	7702	7949	8195	8641	9096	9556	10005	10455	11129	11576
27	J	7456	7702	7949	8195	8641	9096	9556	10005	10455	11129	11576
27	U	7456	7702	7949	8195	8641	9096	9556	10005	10455	11129	11576
27	Q	7794	8051	8308	8565	9031	9506	9992	10459	10928	11634	12100
28	B	7823	8081	8340	8598	9063	9544	10029	10499	10969	11679	12148
29	U	8211	8481	8752	9022	9513	10016	10523	11017	11511	12256	12745

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX A Negotiated Rates of Pay****Section 310.TABLE AD RC-184 (Public Service Administrators Option 8X Department of Natural Resources, SEIU Local 73)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
<u>Blasting Expert</u>	<u>04720</u>	<u>RC-184</u>	<u>22</u>
<u>Blasting Specialist</u>	<u>04725</u>	<u>RC-184</u>	<u>21</u>
<u>Blasting Supervisor</u>	<u>04730</u>	<u>RC-184</u>	<u>23</u>

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
<del>Public Service Administrator, Option 8X (blasting specialist function)</del>	<del>37015</del>	<del>RC-184</del>	<del>21</del>
<del>Public Service Administrator, Option 8X (blasting expert function)</del>	<del>37015</del>	<del>RC-184</del>	<del>22</del>
<del>Public Service Administrator, Option 8X (blasting supervisor function)</del>	<del>37015</del>	<del>RC-184</del>	<del>23</del>

~~NOTE: The positions allocated to the Public Service Administrator title that are assigned to the negotiated RC-184 pay grades have the Option 8X. See the definition of option in Section 310.50.~~

**Effective July 1, 2012  
Bargaining Unit: RC-184**

Pay Grade	Pay Plan Code	S T E P S							
		1	2	3	4	5	6	7	8
21	B	5432	5713	5988	6267	6553	6825	7252	7541
22	B	5743	6044	6337	6638	6945	7233	7684	7992
23	B	6091	6415	6744	7063	7389	7710	8196	8525

**Effective April 1, 2013**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Bargaining Unit: RC-184**

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
21	B	4943	5106	5269	5432	5713	5988	6267	6553	6825	7252	7541
22	B	5226	5398	5571	5743	6044	6337	6638	6945	7233	7684	7992
23	B	5543	5726	5908	6091	6415	6744	7063	7389	7710	8196	8525

**Effective July 1, 2013**  
**Bargaining Unit: RC-184**

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
21	B	5042	5208	5374	5541	5827	6108	6392	6684	6962	7397	7692
22	B	5331	5506	5682	5858	6165	6464	6771	7084	7378	7838	8152
23	B	5654	5841	6026	6213	6543	6879	7204	7537	7864	8360	8696

**Effective July 1, 2014**  
**Bargaining Unit: RC-184**

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
21	B	5143	5312	5481	5652	5944	6230	6520	6818	7101	7545	7846
22	B	5438	5616	5796	5975	6288	6593	6906	7226	7526	7995	8315
23	B	5767	5958	6147	6337	6674	7017	7348	7688	8021	8527	8870

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX B Frozen Negotiated-Rates-of-Pay****Section 310.TABLE J Frozen RC-014-Rates-of-Pay (Clerical Employees, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Account Clerk I	00111	RC-014	05
Account Clerk II	00112	RC-014	07
Account Technician I	00115	RC-014	10
Account Technician II	00116	RC-014	12
Administrative Services Worker Trainee	00600	RC-014	02
Aircraft Dispatcher	00951	RC-014	12
Aircraft Lead Dispatcher	00952	RC-014	14
Audio Visual Technician I	03501	RC-014	06
Audio Visual Technician II	03502	RC-014	09
Buyer Assistant	05905	RC-014	10
Check Issuance Machine Operator	06920	RC-014	09
Check Issuance Machine Supervisor	06925	RC-014	11
Clerical Trainee	08050	RC-014	TR
Communications Dispatcher	08815	RC-014	09
Communications Equipment Technician I	08831	RC-014	17
Communications Equipment Technician II	08832	RC-014	19
Communications Equipment Technician III	08833	RC-014	20
Court Reporter	09900	RC-014	15
Data Processing Assistant	11420	RC-014	06
Data Processing Operator	11425	RC-014	04
Data Processing Operator Trainee	11428	RC-014	02
Drafting Worker	12749	RC-014	11
Electronic Equipment Installer/Repairer	13340	RC-014	10
Electronic Equipment Installer/Repairer Lead Worker	13345	RC-014	12
Electronics Technician	13360	RC-014	15
Emergency Response Lead Telecommunicator	13540	RC-014	13
Emergency Response Telecommunicator	13543	RC-014	11
Engineering Technician II	13732	RC-014	13
Engineering Technician III	13733	RC-014	16
Executive Secretary I	14031	RC-014	11
Executive Secretary II	14032	RC-014	14
Executive Secretary III	14033	RC-014	16
Graphic Arts Designer	17366	RC-014	14

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Graphic Arts Designer Advanced	17370	RC-014	16
Graphic Arts Designer Supervisor	17365	RC-014	18
Graphic Arts Technician	17400	RC-014	12
Human Resources Assistant	19690	RC-014	08
Human Resources Associate	19691	RC-014	11
Industrial Commission Reporter	21080	RC-014	16
Industrial Commission Technician	21095	RC-014	11
Insurance Analyst I	21561	RC-014	09
Insurance Analyst II	21562	RC-014	12
Insurance Analyst Trainee	21566	RC-014	07
Intermittent Clerk	21686	RC-014	02H
Library Aide I	23421	RC-014	03
Library Aide II	23422	RC-014	05
Library Aide III	23423	RC-014	07
Library Technical Assistant	23450	RC-014	10
Lottery Telemarketing Representative	24520	RC-014	09
Microfilm Laboratory Technician I	27175	RC-014	07
Microfilm Laboratory Technician II	27176	RC-014	09
Microfilm Operator I	27181	RC-014	04
Microfilm Operator II	27182	RC-014	06
Microfilm Operator III	27183	RC-014	08
Office Administrator I	29991	RC-014	07
Office Administrator II	29992	RC-014	09
Office Administrator III	29993	RC-014	11
Office Aide	30005	RC-014	02
Office Assistant	30010	RC-014	06
Office Associate	30015	RC-014	08
Office Clerk	30020	RC-014	04
Office Coordinator	30025	RC-014	09
<u>Photographer</u>	<u>32080</u>	<u>RC-014</u>	<u>14</u>
<u>Photographer I</u>	<u>32085</u>	<u>RC-014</u>	<u>11</u>
<u>Photographer II</u>	<u>32086</u>	<u>RC-014</u>	<u>14</u>
<u>Photographer III</u>	<u>32087</u>	<u>RC-014</u>	<u>15</u>
Photographic Technician I	32091	RC-014	11
Photographic Technician II	32092	RC-014	14
Photographic Technician III	32093	RC-014	15
Procurement Representative	34540	RC-014	09
Property and Supply Clerk I	34791	RC-014	03.5
Property and Supply Clerk II	34792	RC-014	05.5

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Property and Supply Clerk III	34793	RC-014	08
Rehabilitation Case Coordinator I	38141	RC-014	08
Rehabilitation Case Coordinator II	38142	RC-014	10
Reproduction Service Supervisor I	38201	RC-014	13
Reproduction Service Technician I	38203	RC-014	05
Reproduction Service Technician II	38204	RC-014	09
Reproduction Service Technician III	38205	RC-014	11
Safety Responsibility Analyst	38910	RC-014	12
Safety Responsibility Analyst Supervisor	38915	RC-014	14
Storekeeper I	43051	RC-014	10.5
Storekeeper II	43052	RC-014	12.5
Storekeeper III	43053	RC-014	14
Stores Clerk	43060	RC-014	04.5
Switchboard Operator I	44411	RC-014	05
Switchboard Operator II	44412	RC-014	07
Switchboard Operator III	44413	RC-014	09
Telecommunications Supervisor	45305	RC-014	20
Telecommunicator	45321	RC-014	12
Telecommunicator – Command Center	45316	RC-014	13
Telecommunicator Call Taker	45322	RC-014	14
Telecommunicator Lead Call Taker	45323	RC-014	16
Telecommunicator Lead Specialist	45327	RC-014	17
Telecommunicator Lead Worker	45324	RC-014	14
Telecommunicator Lead Worker – Command Center	45318	RC-014	15
Telecommunicator Specialist	45326	RC-014	15
Telecommunicator Trainee	45325	RC-014	10
Vehicle Permit Evaluator	47585	RC-014	11
Veterans Service Officer Associate	47804	RC-014	13

NOTE: RC-014-TR is at least the minimum wage and below the minimum frozen rate in the pay grade of the targeted title. The targeted title is the lowest entry level position in the office, either Office Aide (pay grade RC-014-02), Office Clerk (pay grade RC-014-04) or, for the Department of Corrections only, Office Assistant (pay grade RC-014-06).

**Effective July 1, 2011**  
**Bargaining Unit: RC-014**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>S T E P S</u>							
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
02	B	2527	2583	2641	2711	2772	2837	2942	3059
02	Q	2623	2685	2744	2816	2884	2950	3059	3181
02	S	2695	2751	2811	2886	2953	3018	3127	3253
02H	B	15.55	15.90	16.25	16.68	17.06	17.46	18.10	18.82
02H	Q	16.14	16.52	16.89	17.33	17.75	18.15	18.82	19.58
02H	S	16.58	16.93	17.30	17.76	18.17	18.57	19.24	20.02
03	B	2583	2641	2712	2776	2843	2911	3030	3152
03	Q	2685	2744	2817	2887	2955	3024	3152	3279
03	S	2751	2811	2887	2956	3022	3092	3220	3347
03.5	B	2641	2707	2776	2845	2911	2984	3110	3233
03.5	Q	2744	2813	2887	2957	3024	3100	3232	3363
03.5	S	2811	2884	2956	3025	3092	3170	3303	3435
04	B	2641	2712	2784	2847	2926	2992	3119	3246
04	Q	2744	2817	2891	2959	3042	3110	3243	3373
04	S	2811	2887	2960	3029	3112	3177	3311	3444
04.5	B	2707	2776	2846	2921	2997	3066	3195	3323
04.5	Q	2813	2887	2958	3036	3115	3188	3324	3457
04.5	S	2884	2956	3028	3102	3181	3258	3395	3529
05	B	2712	2789	2860	2934	3006	3080	3207	3334
05	Q	2817	2895	2973	3049	3124	3203	3334	3467
05	S	2887	2962	3042	3120	3195	3271	3404	3539
05.5	B	2776	2847	2931	3005	3080	3161	3290	3419
05.5	Q	2887	2959	3047	3123	3203	3290	3420	3558
05.5	S	2956	3029	3117	3194	3271	3357	3490	3629

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

06	B	2789	2862	2938	3020	3097	3183	3318	3450
06	Q	2895	2974	3056	3141	3223	3309	3450	3588
06	S	2962	3043	3122	3212	3293	3379	3522	3664
07	B	2862	2942	3028	3114	3197	3288	3437	3574
07	Q	2974	3059	3150	3236	3326	3419	3578	3723
07	S	3043	3127	3217	3306	3397	3487	3650	3795
08	B	2942	3035	3124	3223	3311	3405	3566	3709
08	Q	3059	3159	3249	3354	3443	3548	3714	3864
08	S	3127	3224	3318	3424	3517	3618	3785	3936
09	B	3035	3129	3229	3329	3436	3537	3705	3853
09	Q	3159	3255	3361	3464	3576	3683	3860	4016
09	S	3224	3323	3429	3535	3649	3755	3933	4091
10	B	3132	3248	3343	3454	3563	3673	3861	4017
10	Q	3259	3377	3480	3599	3711	3827	4031	4192
10	S	3326	3445	3551	3668	3781	3905	4106	4270
10.5	B	3225	3329	3443	3549	3672	3779	3973	4132
10.5	Q	3358	3464	3585	3698	3825	3940	4143	4311
10.5	S	3426	3535	3658	3767	3904	4018	4224	4394
11	B	3249	3359	3467	3593	3711	3826	4029	4190
11	Q	3379	3500	3614	3743	3869	3990	4206	4374
11	S	3446	3568	3682	3815	3941	4066	4281	4451
12	B	3379	3504	3618	3753	3876	4020	4235	4403
12	Q	3518	3648	3769	3914	4046	4193	4423	4599
12	S	3586	3718	3839	3988	4124	4272	4501	4681
12.5	B	3460	3587	3712	3854	3985	4117	4342	4515
12.5	Q	3604	3737	3871	4020	4162	4296	4538	4718
12.5	S	3673	3810	3943	4098	4239	4374	4618	4801

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

13	B	3507	3635	3774	3915	4057	4210	4443	4621
13	Q	3652	3785	3934	4089	4238	4394	4644	4829
13	S	3722	3859	4011	4167	4313	4474	4724	4913
14	B	3656	3795	3943	4117	4266	4428	4686	4874
14	Q	3812	3957	4119	4296	4458	4628	4898	5092
14	S	3882	4035	4192	4374	4536	4708	4975	5172
15	B	3802	3970	4133	4294	4470	4636	4915	5110
15	Q	3967	4140	4313	4487	4673	4845	5134	5341
15	S	4040	4218	4389	4567	4752	4923	5215	5423
16	B	3979	4157	4342	4521	4711	4899	5188	5395
16	Q	4152	4342	4538	4727	4922	5119	5424	5642
16	S	4232	4420	4618	4809	5001	5200	5499	5719
17	B	4170	4361	4562	4756	4949	5149	5455	5674
17	Q	4350	4559	4769	4967	5169	5381	5700	5930
17	S	4429	4639	4849	5050	5249	5458	5784	6014
18	B	4388	4599	4814	5033	5237	5448	5772	6004
18	Q	4583	4811	5032	5261	5475	5693	6035	6275
18	S	4660	4886	5110	5340	5555	5775	6111	6357
19	B	4624	4860	5089	5324	5550	5781	6133	6378
19	Q	4832	5080	5315	5569	5800	6044	6408	6665
19	S	4914	5160	5397	5647	5881	6124	6486	6746
20	B	4885	5133	5371	5626	5872	6115	6485	6745
20	Q	5106	5363	5616	5882	6135	6390	6781	7051
20	S	5187	5443	5693	5960	6214	6470	6857	7131

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX B Frozen Negotiated-Rates-of-Pay****Section 310.TABLE S Frozen VR-704-Rates-of-Pay (Departments of Corrections, Financial and Professional Regulation, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Clinical Services Supervisor	08260	VR-704	24
Forensic Science Administrator I	15911	VR-704	24
Forensic Science Administrator II	15912	VR-704	25
Juvenile Justice Chief of Security	21965	VR-704	24
Police Lieutenant	32977	VR-704	24
Public Service Administrator, Option 7 (inspector sworn and sex offender registry supervisor non-sworn functions at Department of State Police)	37015	VR-704	26
Public Service Administrator, Options 7 (criminal intelligence analyst supervisor, strategic management policy administrator, firearms specialist, computer evidence recovery specialist, and narcotics and currency unit supervisor non-sworn functions at Department of State Police, statewide enforcement function at Department of Financial and Professional Regulation, and superintendent, operations center supervisor and training academy supervisor functions at Department of Corrections) and 8K (Departments of Corrections, Human Services and Juvenile Justice)	37015	VR-704	25
Public Service Administrator, Options 7 (women and family services coordinator, district supervisor, staff assistant and deputy commander of intelligence functions at Department of Corrections and investigator function at Department of Human Services in the Office of the Inspector General), 8L (at <u>DepartmentsDepartment of Corrections and State Police</u> ) and 8J (dietary manager function at Department of Corrections)	37015	VR-704	24
<u>Senior Public Service Administrator, Option 7 (research and development unit chief function at Department of State Police)</u>	<u>40070</u>	<u>VR-704</u>	<u>24</u>

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>Senior Public Service Administrator, Option 7 (protected services unit operations commander and senior terrorism advisor functions at Department of State Police)</u>	<u>40070</u>	<u>VR-704</u>	<u>25</u>
<u>Senior Public Service Administrator, Option 7 (assistant director of forensic science training, quality assurance and safety director and section chief functions at Department of State Police)</u>	<u>40070</u>	<u>VR-704</u>	<u>26</u>
<u>Senior Public Service Administrator, Option 7 (deputy laboratory director function at Department of State Police)</u>	<u>40070</u>	<u>VR-704</u>	<u>27</u>
Shift Supervisor	40800	VR-704	24
<u>Shift Supervisor – Hired on or after August 1, 2010</u>	<u>40800</u>	<u>VR-704</u>	<u>23</u>

NOTE: The positions allocated to the Public Service Administrator title that are assigned to a frozen negotiated VR-704 pay grade have the following Options: 7; 8J; 8K; and 8L. The positions allocated to the Senior Public Service Administrator title that are assigned to a frozen negotiated VR-704 pay grade have the Option 7. See the definition of option in Section 310.50.

**Effective July 1, 2011  
Bargaining Unit: VR-704**

Pay Grade	Pay Plan Code	S T E P S							
		1	2	3	4	5	6	7	8
<u>23</u>	<u>Q</u>	<u>6114</u>	<u>6440</u>	<u>6774</u>	<u>7101</u>	<u>7425</u>	<u>7762</u>	<u>8251</u>	<u>8580</u>
<u>23</u>	<u>S</u>	<u>6190</u>	<u>6512</u>	<u>6849</u>	<u>7174</u>	<u>7503</u>	<u>7840</u>	<u>8324</u>	<u>8657</u>
24	B	6157	6484	6825	7150	7482	7818	8310	8641
24	Q	6436	6779	7131	7475	7816	8171	8685	9032
24	S	6516	6855	7209	7552	7898	8253	8762	9113
25	B	6563	6921	7286	7650	8013	8378	8915	9273
25	Q	6856	7233	7611	7997	8377	8756	9318	9691
25	S	6937	7313	7691	8073	8454	8832	9397	9774

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

26	B	7003	7386	7779	8172	8553	8937	9515	9894	
26	Q	7340	7739	8149	8561	8961	9361	9967	10365	
	<u>27</u>	<u>B</u>	<u>7476</u>	<u>7883</u>	<u>8299</u>	<u>8719</u>	<u>9127</u>	<u>9537</u>	<u>10153</u>	<u>10560</u>

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX B Frozen Negotiated-Rates-of-Pay****Section 310.TABLE W Frozen RC-062-Rates-of-Pay (Technical Employees, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Accountant	00130	RC-062	14
Accountant Advanced	00133	RC-062	16
Accountant Supervisor	00135	RC-062	18
Accounting and Fiscal Administration Career Trainee	00140	RC-062	12
Activity Therapist	00157	RC-062	15
Activity Therapist Coordinator	00160	RC-062	17
Activity Therapist Supervisor	00163	RC-062	20
Actuarial Assistant	00187	RC-062	16
Actuarial Examiner	00195	RC-062	16
Actuarial Examiner Trainee	00196	RC-062	13
Actuarial Senior Examiner	00197	RC-062	19
Actuary I	00201	RC-062	20
Actuary II	00202	RC-062	24
Agricultural Market News Assistant	00804	RC-062	12
Agricultural Marketing Generalist	00805	RC-062	14
Agricultural Marketing Reporter	00807	RC-062	18
Agricultural Marketing Representative	00810	RC-062	18
Agriculture Land and Water Resource Specialist I	00831	RC-062	14
Agriculture Land and Water Resource Specialist II	00832	RC-062	17
Agriculture Land and Water Resource Specialist III	00833	RC-062	20
Aircraft Pilot I	00955	RC-062	19
Aircraft Pilot II	00956	RC-062	22
Aircraft Pilot II – Dual Rating	00957	RC-062	23
Appraisal Specialist I	01251	RC-062	14
Appraisal Specialist II	01252	RC-062	16
Appraisal Specialist III	01253	RC-062	18
Arts Council Associate	01523	RC-062	12
Arts Council Program Coordinator	01526	RC-062	18
Arts Council Program Representative	01527	RC-062	15
Assignment Coordinator	01530	RC-062	20
Bank Examiner I	04131	RC-062	16
Bank Examiner II	04132	RC-062	19
Bank Examiner III	04133	RC-062	22

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Behavioral Analyst Associate	04355	RC-062	15
Behavioral Analyst I	04351	RC-062	17
Behavioral Analyst II	04352	RC-062	19
Business Administrative Specialist	05810	RC-062	16
Business Manager	05815	RC-062	18
Buyer	05900	RC-062	18
<u>Cancer Registrar I</u>	<u>05951</u>	<u>RC-062</u>	<u>14</u>
Cancer Registrar II	05952	RC-062	16
<u>Cancer Registrar III</u>	<u>05953</u>	<u>RC-062</u>	<u>20</u>
<u>Cancer Registrar Assistant Manager</u>	<u>05954</u>	<u>RC-062</u>	<u>22</u>
<u>Cancer Registrar Manager</u>	<u>05955</u>	<u>RC-062</u>	<u>24</u>
Capital Development Board Account Technician	06515	RC-062	11
Capital Development Board Art in Architecture Technician	06533	RC-062	12
Capital Development Board Construction Support Analyst	06520	RC-062	11
Capital Development Board Project Technician	06530	RC-062	12
Chemist I	06941	RC-062	16
Chemist II	06942	RC-062	19
Chemist III	06943	RC-062	21
Child Protection Advanced Specialist	07161	RC-062	19
Child Protection Associate Specialist	07162	RC-062	16
Child Protection Specialist	07163	RC-062	18
Child Support Specialist I	07198	RC-062	16
Child Support Specialist II	07199	RC-062	17
Child Support Specialist Trainee	07200	RC-062	12
Child Welfare Associate Specialist	07216	RC-062	16
Child Welfare Staff Development Coordinator I	07201	RC-062	17
Child Welfare Staff Development Coordinator II	07202	RC-062	19
Child Welfare Staff Development Coordinator III	07203	RC-062	20
Child Welfare Staff Development Coordinator IV	07204	RC-062	22
Children and Family Service Intern – Option I	07241	RC-062	12
Children and Family Service Intern – Option II	07242	RC-062	15
Clinical Laboratory Technologist I	08220	RC-062	18
Clinical Laboratory Technologist II	08221	RC-062	19
Clinical Laboratory Technologist Trainee	08229	RC-062	14
Communications Systems Specialist	08860	RC-062	23
Community Management Specialist I	08891	RC-062	15
Community Management Specialist II	08892	RC-062	17

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Community Management Specialist III	08893	RC-062	19
Community Planner I	08901	RC-062	15
Community Planner II	08902	RC-062	17
Community Planner III	08903	RC-062	19
Conservation Education Representative	09300	RC-062	12
Conservation Grant Administrator I	09311	RC-062	18
Conservation Grant Administrator II	09312	RC-062	20
Conservation Grant Administrator III	09313	RC-062	22
Construction Program Assistant	09525	RC-062	12
Correctional Counselor I	09661	RC-062	15
Correctional Counselor II	09662	RC-062	17
Correctional Counselor III	09663	RC-062	19
Corrections Apprehension Specialist	09750	RC-062	19
Corrections Industries Marketing Representative	09803	RC-062	17
Corrections Leisure Activities Specialist I	09811	RC-062	15
Corrections Leisure Activities Specialist II	09812	RC-062	17
Corrections Leisure Activities Specialist III	09813	RC-062	19
Corrections Parole Agent	09842	RC-062	17
Corrections Senior Parole Agent	09844	RC-062	19
Criminal Intelligence Analyst I	10161	RC-062	18
Criminal Intelligence Analyst II	10162	RC-062	20
Criminal Intelligence Analyst Specialist	10165	RC-062	22
Criminal Justice Specialist I	10231	RC-062	16
Criminal Justice Specialist II	10232	RC-062	20
Criminal Justice Specialist Trainee	10236	RC-062	13
Curator of the Lincoln Collection	10750	RC-062	16
Data Processing Supervisor I	11435	RC-062	11
Data Processing Supervisor II	11436	RC-062	14
Data Processing Supervisor III	11437	RC-062	18
Day Care Licensing Representative I	11471	RC-062	16
Developmental Disabilities Council Program Planner I	12361	RC-062	12
Developmental Disabilities Council Program Planner II	12362	RC-062	16
Developmental Disabilities Council Program Planner III	12363	RC-062	18
Dietary Manager I	12501	RC-062	16
Dietary Manager II	12502	RC-062	18
Dietitian	12510	RC-062	15

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Disability Appeals Officer	12530	RC-062	22
Disability Claims Adjudicator I	12537	RC-062	16
Disability Claims Adjudicator II	12538	RC-062	18
Disability Claims Adjudicator Trainee	12539	RC-062	13
Disability Claims Analyst	12540	RC-062	21
Disability Claims Specialist	12558	RC-062	19
Disaster Services Planner	12585	RC-062	19
Document Examiner	12640	RC-062	22
Economic Development Representative I	12931	RC-062	17
Economic Development Representative II	12932	RC-062	19
Educational Diagnostician	12965	RC-062	12
Educator – Provisional	13105	RC-062	12
Employment Security Field Office Supervisor	13600	RC-062	20
Employment Security Manpower Representative I	13621	RC-062	12
Employment Security Manpower Representative II	13622	RC-062	14
Employment Security Program Representative	13650	RC-062	14
Employment Security Program Representative – Intermittent	13651	RC-062	14H
Employment Security Service Representative	13667	RC-062	16
Employment Security Service Representative (Intermittent)	13667	RC-062	16H
Employment Security Specialist I	13671	RC-062	14
Employment Security Specialist II	13672	RC-062	16
Employment Security Specialist III	13673	RC-062	19
Employment Security Tax Auditor I	13681	RC-062	17
Employment Security Tax Auditor II	13682	RC-062	19
Energy and Natural Resources Specialist I	13711	RC-062	15
Energy and Natural Resources Specialist II	13712	RC-062	17
Energy and Natural Resources Specialist III	13713	RC-062	19
Energy and Natural Resources Specialist Trainee	13715	RC-062	12
Engineering Technician IV (Department of Public Health)	13734	RC-062	18
Environmental Health Specialist I	13768	RC-062	14
Environmental Health Specialist II	13769	RC-062	16
Environmental Health Specialist III	13770	RC-062	18
Environmental Protection Associate	13785	RC-062	12
Environmental Protection Specialist I	13821	RC-062	14
Environmental Protection Specialist II	13822	RC-062	16
Environmental Protection Specialist III	13823	RC-062	18

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Environmental Protection Specialist IV	13824	RC-062	22
Equal Pay Specialist	13837	RC-062	17
Executive I	13851	RC-062	18
Executive II	13852	RC-062	20
Financial Institutions Examiner I	14971	RC-062	16
Financial Institutions Examiner II	14972	RC-062	19
Financial Institutions Examiner III	14973	RC-062	22
Financial Institutions Examiner Trainee	14978	RC-062	13
Fire Protection Specialist I	15351	RC-062	16
Flight Safety Coordinator	15640	RC-062	22
Forensic Scientist I	15891	RC-062	18
Forensic Scientist II	15892	RC-062	20
Forensic Scientist III	15893	RC-062	22
Forensic Scientist Trainee	15897	RC-062	15
Gaming Licensing Analyst	17171	RC-062	13
Gaming Senior Special Agent	17191	RC-062	23
Gaming Special Agent	17192	RC-062	19
Gaming Special Agent Trainee	17195	RC-062	14
Guardianship Representative	17710	RC-062	17
Habilitation Program Coordinator	17960	RC-062	17
Handicapped Services Representative I	17981	RC-062	11
Health Facilities Surveyor I	18011	RC-062	16
Health Facilities Surveyor II	18012	RC-062	19
Health Facilities Surveyor III	18013	RC-062	20
Health Information Administrator	18041	RC-062	15
Health Services Investigator I – Opt. A	18181	RC-062	19
Health Services Investigator I – Opt. B	18182	RC-062	20
Health Services Investigator II – Opt. A	18185	RC-062	22
Health Services Investigator II – Opt. B	18186	RC-062	22
Health Services Investigator II – Opt. C	18187	RC-062	25
Health Services Investigator II – Opt. D	18188	RC-062	25
Historical Documents Conservator I	18981	RC-062	13
Historical Exhibits Designer	18985	RC-062	15
Historical Research Editor II	19002	RC-062	14
Human Relations Representative	19670	RC-062	16
Human Resources Representative	19692	RC-062	17
Human Resources Specialist	19693	RC-062	20
Human Rights Investigator I	19774	RC-062	16
Human Rights Investigator II	19775	RC-062	18

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Human Rights Investigator III	19776	RC-062	19
Human Rights Mediator	19771	RC-062	17
Human Rights Specialist I	19778	RC-062	14
Human Rights Specialist II	19779	RC-062	16
Human Rights Specialist III	19780	RC-062	18
Human Services Casework Manager	19788	RC-062	20
Human Services Caseworker	19785	RC-062	16
Human Services Grants Coordinator I	19791	RC-062	14
Human Services Grants Coordinator II	19792	RC-062	17
Human Services Grants Coordinator III	19793	RC-062	20
Human Services Grants Coordinator Trainee	19796	RC-062	12
Human Services Sign Language Interpreter	19810	RC-062	16
Iconographer	19880	RC-062	12
Industrial and Community Development Representative I	21051	RC-062	17
Industrial and Community Development Representative II	21052	RC-062	19
Industrial Services Consultant I	21121	RC-062	14
Industrial Services Consultant II	21122	RC-062	16
Industrial Services Consultant Trainee	21125	RC-062	11
Industrial Services Hygienist	21127	RC-062	19
Industrial Services Hygienist Technician	21130	RC-062	16
Industrial Services Hygienist Trainee	21133	RC-062	12
Information Technology/Communication Systems Specialist I	21216	RC-062	19
Information Technology/Communication Systems Specialist II	21217	RC-062	24
Instrument Designer	21500	RC-062	18
Insurance Analyst III	21563	RC-062	14
Insurance Analyst IV	21564	RC-062	16
Insurance Company Claims Examiner II	21602	RC-062	19
Insurance Company Field Staff Examiner	21608	RC-062	16
Insurance Company Financial Examiner Trainee	21610	RC-062	13
Insurance Performance Examiner I	21671	RC-062	14
Insurance Performance Examiner II	21672	RC-062	17
Insurance Performance Examiner III	21673	RC-062	20
Intermittent Unemployment Insurance Representative	21689	RC-062	12H
Internal Auditor I	21721	RC-062	17

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Internal Security Investigator I, not Department of Corrections	21731	RC-062	18
Internal Security Investigator II, not Department of Corrections	21732	RC-062	21
International Marketing Representative I, Department of Agriculture	21761	RC-062	14
Juvenile Justice Youth and Family Specialist, Option 1	21991	RC-062	18
Juvenile Justice Youth and Family Specialist, Option 2	21992	RC-062	20
KidCare Supervisor	22003	RC-062	20
Labor Conciliator	22750	RC-062	20
Laboratory Equipment Specialist	22990	RC-062	18
Laboratory Quality Specialist I	23021	RC-062	19
Laboratory Quality Specialist II	23022	RC-062	21
Laboratory Research Specialist I	23027	RC-062	19
Laboratory Research Specialist II	23028	RC-062	21
Land Acquisition Agent I	23091	RC-062	15
Land Acquisition Agent II	23092	RC-062	18
Land Acquisition Agent III	23093	RC-062	21
Land Reclamation Specialist I	23131	RC-062	14
Land Reclamation Specialist II	23132	RC-062	17
Liability Claims Adjuster I	23371	RC-062	14
Liability Claims Adjuster II	23372	RC-062	18
Library Associate	23430	RC-062	12
Life Sciences Career Trainee	23600	RC-062	12
Liquor Control Special Agent II	23752	RC-062	15
Local Historical Services Representative	24000	RC-062	17
Local Housing Advisor I	24031	RC-062	14
Local Housing Advisor II	24032	RC-062	16
Local Housing Advisor III	24033	RC-062	18
Local Revenue and Fiscal Advisor I	24101	RC-062	15
Local Revenue and Fiscal Advisor II	24102	RC-062	17
Local Revenue and Fiscal Advisor III	24103	RC-062	19
Lottery Regional Coordinator	24504	RC-062	19
Lottery Sales Representative	24515	RC-062	16
Management Operations Analyst I	25541	RC-062	18
Management Operations Analyst II	25542	RC-062	20
Manpower Planner I	25591	RC-062	14

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Manpower Planner II	25592	RC-062	17
Manpower Planner III	25593	RC-062	20
Manpower Planner Trainee	25597	RC-062	12
Medical Assistance Consultant I	26501	RC-062	13
Medical Assistance Consultant II	26502	RC-062	16
Medical Assistance Consultant III	26503	RC-062	19
Mental Health Administrator I	26811	RC-062	18
Mental Health Administrator II	26812	RC-062	20
Mental Health Administrator Trainee	26817	RC-062	16
Mental Health Recovery Support Specialist I	26921	RC-062	17
Mental Health Recovery Support Specialist II	26922	RC-062	18
Mental Health Specialist I	26924	RC-062	12
Mental Health Specialist II	26925	RC-062	14
Mental Health Specialist III	26926	RC-062	16
Mental Health Specialist Trainee	26928	RC-062	11
Meteorologist	27120	RC-062	18
Methods and Procedures Advisor I	27131	RC-062	14
Methods and Procedures Advisor II	27132	RC-062	16
Methods and Procedures Advisor III	27133	RC-062	20
Methods and Procedures Career Associate I	27135	RC-062	11
Methods and Procedures Career Associate II	27136	RC-062	12
Methods and Procedures Career Associate Trainee	27137	RC-062	09
Metrologist Associate	27146	RC-062	15
Microbiologist I	27151	RC-062	16
Microbiologist II	27152	RC-062	19
Natural Resources Advanced Specialist	28833	RC-062	20
Natural Resources Coordinator	28831	RC-062	15
Natural Resources Specialist	28832	RC-062	18
Oral Health Consultant	30317	RC-062	18
Paralegal Assistant	30860	RC-062	14
Pension and Death Benefits Technician I	30961	RC-062	12
Pension and Death Benefits Technician II	30962	RC-062	19
Plumbing Consultant (Department of Public Health)	32910	RC-062	22
Police Training Specialist	32990	RC-062	17
Program Integrity Auditor I	34631	RC-062	16
Program Integrity Auditor II	34632	RC-062	19
Program Integrity Auditor Trainee	34635	RC-062	12
Property Consultant	34900	RC-062	15
Public Aid Investigator	35870	RC-062	19

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Public Aid Investigator Trainee	35874	RC-062	14
Public Aid Lead Casework Specialist	35880	RC-062	17
Public Aid Program Quality Analyst	35890	RC-062	19
Public Aid Quality Control Reviewer	35892	RC-062	17
Public Aid Quality Control Supervisor	35900	RC-062	19
Public Aid Staff Development Specialist I	36071	RC-062	15
Public Aid Staff Development Specialist II	36072	RC-062	17
Public Health Educator Associate	36434	RC-062	14
Public Health Program Specialist I	36611	RC-062	14
Public Health Program Specialist II	36612	RC-062	16
Public Health Program Specialist III	36613	RC-062	19
Public Health Program Specialist Trainee	36615	RC-062	12
Public Information Coordinator	36750	RC-062	18
Public Information Officer I	37001	RC-062	12
Public Information Officer II	37002	RC-062	14
Public Information Officer III	37003	RC-062	19
Public Information Officer IV	37004	RC-062	21
Public Safety Inspector	37007	RC-062	16
Public Safety Inspector Trainee	37010	RC-062	10
Public Service Administrator, Option 8Z	37015	RC-062	19
Public Service Administrator, Options 2, 7 Gaming Board and Departments of Healthcare and Family Services and Revenue, 8C, 8F executive chief pilot function Department of Transportation, 9A and 9B	37015	RC-062	24
Public Service Administrator, Options 8B and 8Y	37015	RC-062	23
Railroad Safety Specialist I	37601	RC-062	19
Railroad Safety Specialist II	37602	RC-062	21
Railroad Safety Specialist III	37603	RC-062	23
Railroad Safety Specialist IV	37604	RC-062	25
Real Estate Investigator	37730	RC-062	19
Real Estate Professions Examiner	37760	RC-062	22
Recreation Worker I	38001	RC-062	12
Recreation Worker II	38002	RC-062	14
Rehabilitation Counselor	38145	RC-062	17
Rehabilitation Counselor Senior	38158	RC-062	19
Rehabilitation Counselor Trainee	38159	RC-062	15
Rehabilitation Services Advisor I	38176	RC-062	20
Rehabilitation Workshop Supervisor I	38194	RC-062	12

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Rehabilitation Workshop Supervisor II	38195	RC-062	14
Rehabilitation Workshop Supervisor III	38196	RC-062	16
Reimbursement Officer I	38199	RC-062	14
Reimbursement Officer II	38200	RC-062	16
Research Economist I	38207	RC-062	18
Research Scientist I	38231	RC-062	13
Research Scientist II	38232	RC-062	16
Research Scientist III	38233	RC-062	20
Residential Services Supervisor	38280	RC-062	15
Resource Planner I	38281	RC-062	17
Resource Planner II	38282	RC-062	19
Resource Planner III	38283	RC-062	22
Retirement System Disability Specialist	38310	RC-062	19
Revenue Audit Supervisor (IL)	38369	RC-062	25
Revenue Audit Supervisor (states other than IL and not assigned to RC-062-29)	38369	RC-062	27
Revenue Audit Supervisor (See Note)	38369	RC-062	29
Revenue Auditor I (IL)	38371	RC-062	16
Revenue Auditor I (states other than IL and not assigned to RC-062-21)	38371	RC-062	19
Revenue Auditor I (See Note)	38371	RC-062	21
Revenue Auditor II (IL)	38372	RC-062	19
Revenue Auditor II (states other than IL and not assigned to RC-062-24)	38372	RC-062	22
Revenue Auditor II (See Note)	38372	RC-062	24
Revenue Auditor III (IL)	38373	RC-062	22
Revenue Auditor III (states other than IL and not assigned to RC-062-26)	38373	RC-062	24
Revenue Auditor III (See Note)	38373	RC-062	26
Revenue Auditor Trainee (IL)	38375	RC-062	12
Revenue Auditor Trainee (states other than IL and not assigned to RC-062-15)	38375	RC-062	13
Revenue Auditor Trainee (See Note)	38375	RC-062	15
Revenue Collection Officer I	38401	RC-062	15
Revenue Collection Officer II	38402	RC-062	17
Revenue Collection Officer III	38403	RC-062	19
Revenue Collection Officer Trainee	38405	RC-062	12
Revenue Computer Audit Specialist (IL)	38425	RC-062	23
Revenue Computer Audit Specialist (states other	38425	RC-062	25

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

than IL and not assigned to RC-062-27)			
Revenue Computer Audit Specialist (See Note)	38425	RC-062	27
Revenue Senior Special Agent	38557	RC-062	23
Revenue Special Agent	38558	RC-062	19
Revenue Special Agent Trainee	38565	RC-062	14
Revenue Tax Specialist I	38571	RC-062	12
Revenue Tax Specialist II (IL)	38572	RC-062	14
Revenue Tax Specialist II (states other than IL, CA or NJ)	38572	RC-062	17
Revenue Tax Specialist II (CA or NJ)	38572	RC-062	19
Revenue Tax Specialist III	38573	RC-062	17
Revenue Tax Specialist Trainee	38575	RC-062	10
<u>Senior Public Service Administrator, Option 7 Gaming Board and Department of Revenue</u>	<u>40070</u>	<u>RC-062</u>	<u>26</u>
<u>Sex Offender Therapist I</u>	<u>40531</u>	<u>RC-062</u>	<u>17</u>
<u>Sex Offender Therapist II</u>	<u>40532</u>	<u>RC-062</u>	<u>19</u>
Site Assistant Superintendent I	41071	RC-062	15
Site Assistant Superintendent II	41072	RC-062	17
Site Interpretive Coordinator	41093	RC-062	13
Site Services Specialist I	41117	RC-062	15
Site Services Specialist II	41118	RC-062	17
Social Service Consultant I	41301	RC-062	18
Social Service Consultant II	41302	RC-062	19
Social Service Program Planner I	41311	RC-062	15
Social Service Program Planner II	41312	RC-062	17
Social Service Program Planner III	41313	RC-062	20
Social Service Program Planner IV	41314	RC-062	22
Social Services Career Trainee	41320	RC-062	12
Social Worker I	41411	RC-062	17
Staff Development Specialist I	41771	RC-062	18
Staff Development Technician I	41781	RC-062	12
Staff Development Technician II	41782	RC-062	15
State Mine Inspector	42230	RC-062	19
State Police Field Specialist I	42001	RC-062	18
State Police Field Specialist II	42002	RC-062	20
Statistical Research Specialist I	42741	RC-062	12
Statistical Research Specialist II	42742	RC-062	14
Statistical Research Specialist III	42743	RC-062	17
Storage Tank Safety Specialist	43005	RC-062	18

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Telecommunications Specialist	45295	RC-062	15
Telecommunications Systems Analyst	45308	RC-062	17
Telecommunications Systems Technician I	45312	RC-062	10
Telecommunications Systems Technician II	45313	RC-062	13
Terrorism Research Specialist I	45371	RC-062	18
Terrorism Research Specialist II	45372	RC-062	20
Terrorism Research Specialist III	45373	RC-062	22
Terrorism Research Specialist Trainee	45375	RC-062	14
Unemployment Insurance Adjudicator I	47001	RC-062	11
Unemployment Insurance Adjudicator II	47002	RC-062	13
Unemployment Insurance Adjudicator III	47003	RC-062	15
Unemployment Insurance Revenue Analyst I	47081	RC-062	15
Unemployment Insurance Revenue Analyst II	47082	RC-062	17
Unemployment Insurance Revenue Specialist	47087	RC-062	13
Unemployment Insurance Special Agent	47096	RC-062	18
Vehicle Emission Compliance Supervisor, Environmental Protection Agency	47583	RC-062	15
Veterans Educational Specialist I	47681	RC-062	15
Veterans Educational Specialist II	47682	RC-062	17
Veterans Educational Specialist III	47683	RC-062	21
Veterans Employment Representative I	47701	RC-062	14
Veterans Employment Representative II	47702	RC-062	16
Volunteer Services Coordinator I	48481	RC-062	13
Volunteer Services Coordinator II	48482	RC-062	16
Volunteer Services Coordinator III	48483	RC-062	18
Wage Claims Specialist	48770	RC-062	09
Weatherization Specialist I	49101	RC-062	14
Weatherization Specialist II	49102	RC-062	17
Weatherization Specialist III	49103	RC-062	20
Weatherization Specialist Trainee	49105	RC-062	12
Workers Compensation Insurance Compliance Investigator	49640	RC-062	20

NOTE: The positions allocated to the Public Service Administrator title that are assigned to a frozen negotiated RC-062 pay grade have the following Options: 2; 7; 8B; 8C; 8F; 8Y; 8Z; 9A; and 9B. The positions allocated to the Senior Public Service Administrator title that are assigned to a frozen negotiated RC-062 pay grade have the Option 7. See the definition of option in Section 310.50.

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

For the Revenue Tax Specialist II position classification title only – The pay grade assigned to the employee is based on the location of the position and the residence held by the employee. In the same position classification, the employee holding a position and residence outside the boundaries of the State of Illinois is assigned to a different pay grade than the pay grade assigned to the employee holding a position within the boundaries of the State of Illinois. The pay grade assigned to the employee holding a position located within the boundaries of the State of Illinois is the pay grade with the (IL) indication next to the position classification. The pay grade assigned to the employee holding the position located outside the boundaries of the State of Illinois is determined by the location of the employee's residence or position location (e.g., IL, CA or NJ or a state other than IL, CA or NJ). If the employee's residence moves to another state while the employee is in the same position located outside the boundaries of the State of Illinois, or moves into another position located outside the boundaries of the State of Illinois in the same position classification, the base salary may change depending on the location of the employee's new residence. In all cases, change in base salary shall be on a step for step basis (e.g., if the original base salary was on Step 5 in one pay grade, the new base salary will also be on Step 5 of the newly appropriate pay grade).

For the Revenue Audit Supervisor, Revenue Auditor I, II and III, Revenue Auditor Trainee, and Revenue Computer Audit Specialist position classification titles only – Effective July 1, 2010, State employees appointed to positions allocated to the Revenue Audit Supervisor, Revenue Auditor I, II and III, Revenue Auditor Trainee, and Revenue Computer Audit Specialist classifications shall be assigned to the pay grades:

Revenue Audit Supervisor, RC-062-29

Revenue Auditor I, RC-062-21

Revenue Auditor II, RC-062-24

Revenue Auditor III, RC-062-26

Revenue Auditor Trainee, RC-062-25

Revenue Computer Audit Specialist, RC-062-27

if the employee lives in California, 50% or more of the employee's work is within a 200 mile radius of the Paramus NJ Illinois Department of Revenue office, or 50% or more of the employee's work is within the District of Columbia.

**Effective July 1, 2011**  
**Bargaining Unit: RC-062**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>S T E P S</u>							
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
09	B	3035	3129	3229	3329	3436	3537	3705	3853
09	Q	3159	3255	3361	3464	3576	3683	3860	4016
09	S	3224	3323	3429	3535	3649	3755	3933	4091
10	B	3132	3248	3343	3454	3563	3673	3861	4017
10	Q	3259	3377	3480	3599	3711	3827	4031	4192
10	S	3326	3445	3551	3668	3781	3905	4106	4270
11	B	3249	3359	3467	3593	3711	3826	4029	4190
11	Q	3379	3500	3614	3743	3869	3990	4206	4374
11	S	3446	3568	3682	3815	3941	4066	4281	4451
12	B	3379	3504	3618	3753	3876	4020	4235	4403
12	Q	3518	3648	3769	3914	4046	4193	4423	4599
12	S	3586	3718	3839	3988	4124	4272	4501	4681
12H	B	20.79	21.56	22.26	23.10	23.85	24.74	26.06	27.10
12H	Q	21.65	22.45	23.19	24.09	24.90	25.80	27.22	28.30
12H	S	22.07	22.88	23.62	24.54	25.38	26.29	27.70	28.81
13	B	3507	3635	3774	3915	4057	4210	4443	4621
13	Q	3652	3785	3934	4089	4238	4394	4644	4829
13	S	3722	3859	4011	4167	4313	4474	4724	4913
14	B	3656	3795	3943	4117	4266	4428	4686	4874
14	Q	3812	3957	4119	4296	4458	4628	4898	5092
14	S	3882	4035	4192	4374	4536	4708	4975	5172
14H	B	22.50	23.35	24.26	25.34	26.25	27.25	28.84	29.99
14H	Q	23.46	24.35	25.35	26.44	27.43	28.48	30.14	31.34
14H	S	23.89	24.83	25.80	26.92	27.91	28.97	30.62	31.83

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

15	B	3802	3970	4133	4294	4470	4636	4915	5110
15	Q	3967	4140	4313	4487	4673	4845	5134	5341
15	S	4040	4218	4389	4567	4752	4923	5215	5423
16	B	3979	4157	4342	4521	4711	4899	5188	5395
16	Q	4152	4342	4538	4727	4922	5119	5424	5642
16	S	4232	4420	4618	4809	5001	5200	5499	5719
16H	B	24.49	25.58	26.72	27.82	28.99	30.15	31.93	33.20
16H	Q	25.55	26.72	27.93	29.09	30.29	31.50	33.38	34.72
16H	S	26.04	27.20	28.42	29.59	30.78	32.00	33.84	35.19
17	B	4170	4361	4562	4756	4949	5149	5455	5674
17	Q	4350	4559	4769	4967	5169	5381	5700	5930
17	S	4429	4639	4849	5050	5249	5458	5784	6014
18	B	4388	4599	4814	5033	5237	5448	5772	6004
18	Q	4583	4811	5032	5261	5475	5693	6035	6275
18	S	4660	4886	5110	5340	5555	5775	6111	6357
19	B	4624	4860	5089	5324	5550	5781	6133	6378
19	J	4624	4860	5089	5324	5550	5781	6133	6378
19	Q	4832	5080	5315	5569	5800	6044	6408	6665
19	S	4914	5160	5397	5647	5881	6124	6486	6746
20	B	4885	5133	5371	5626	5872	6115	6485	6745
20	Q	5106	5363	5616	5882	6135	6390	6781	7051
20	S	5187	5443	5693	5960	6214	6470	6857	7131
21	B	5159	5425	5687	5952	6223	6482	6887	7162
21	U	5159	5425	5687	5952	6223	6482	6887	7162
21	Q	5392	5671	5942	6221	6505	6777	7197	7485
21	S	5472	5747	6020	6302	6583	6854	7277	7568
22	B	5454	5739	6018	6304	6595	6869	7297	7589

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

22	Q	5698	5998	6292	6586	6891	7181	7625	7928
22	S	5781	6074	6371	6665	6972	7263	7706	8014
23	B	5785	6092	6405	6708	7017	7322	7784	8096
23	Q	6050	6369	6695	7009	7334	7653	8131	8456
23	S	6127	6446	6774	7090	7413	7731	8212	8538
24	B	6158	6484	6826	7151	7483	7819	8311	8642
24	J	6158	6484	6826	7151	7483	7819	8311	8642
24	Q	6436	6780	7132	7476	7817	8172	8685	9033
24	S	6517	6856	7209	7553	7899	8253	8763	9114
25	B	6564	6922	7287	7651	8014	8379	8917	9274
25	J	6564	6922	7287	7651	8014	8379	8917	9274
25	Q	6857	7234	7612	7998	8378	8757	9319	9692
25	S	6938	7313	7692	8074	8454	8833	9397	9775
26	B	7003	7387	7780	8173	8554	8938	9515	9895
26	U	7003	7387	7780	8173	8554	8938	9515	9895
27	B	7477	7884	8300	8720	9129	9539	10155	10562
27	J	7477	7884	8300	8720	9129	9539	10155	10562
27	U	7477	7884	8300	8720	9129	9539	10155	10562
28	B	7845	8270	8709	9150	9579	10008	10656	11084
29	U	8232	8679	9138	9603	10052	10503	11182	11629

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX B Frozen Negotiated-Rates-of-Pay****Section 310.TABLE AD Frozen RC-184-Rates-of-Pay (Public Service Administrators Option 8X Department of Natural Resources, SEIU Local 73)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
<u>Blasting Expert</u>	<u>04720</u>	<u>RC-184</u>	<u>22</u>
<u>Blasting Specialist</u>	<u>04725</u>	<u>RC-184</u>	<u>21</u>
<u>Blasting Supervisor</u>	<u>04730</u>	<u>RC-184</u>	<u>23</u>

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
<del>Public Service Administrator, Option 8X (blasting specialist function)</del>	<del>37015</del>	<del>RC-184</del>	<del>21</del>
<del>Public Service Administrator, Option 8X (blasting expert function)</del>	<del>37015</del>	<del>RC-184</del>	<del>22</del>
<del>Public Service Administrator, Option 8X (blasting supervisor function)</del>	<del>37015</del>	<del>RC-184</del>	<del>23</del>

~~NOTE: The positions allocated to the Public Service Administrator title that are assigned to the frozen negotiated RC-184 pay grades have the Option 8X. See the definition of option in Section 310.50.~~

**Effective July 1, 2011  
Bargaining Unit: RC-184**

Pay Grade	Pay Plan Code	S T E P S							
		1	2	3	4	5	6	7	8
21	B	5159	5425	5687	5952	6223	6482	6887	7162
22	B	5454	5739	6018	6304	6595	6869	7297	7589
23	B	5785	6092	6405	6708	7017	7322	7784	8096

(Source: Amended at 37 Ill. Reg. 9939, effective July 1, 2013)

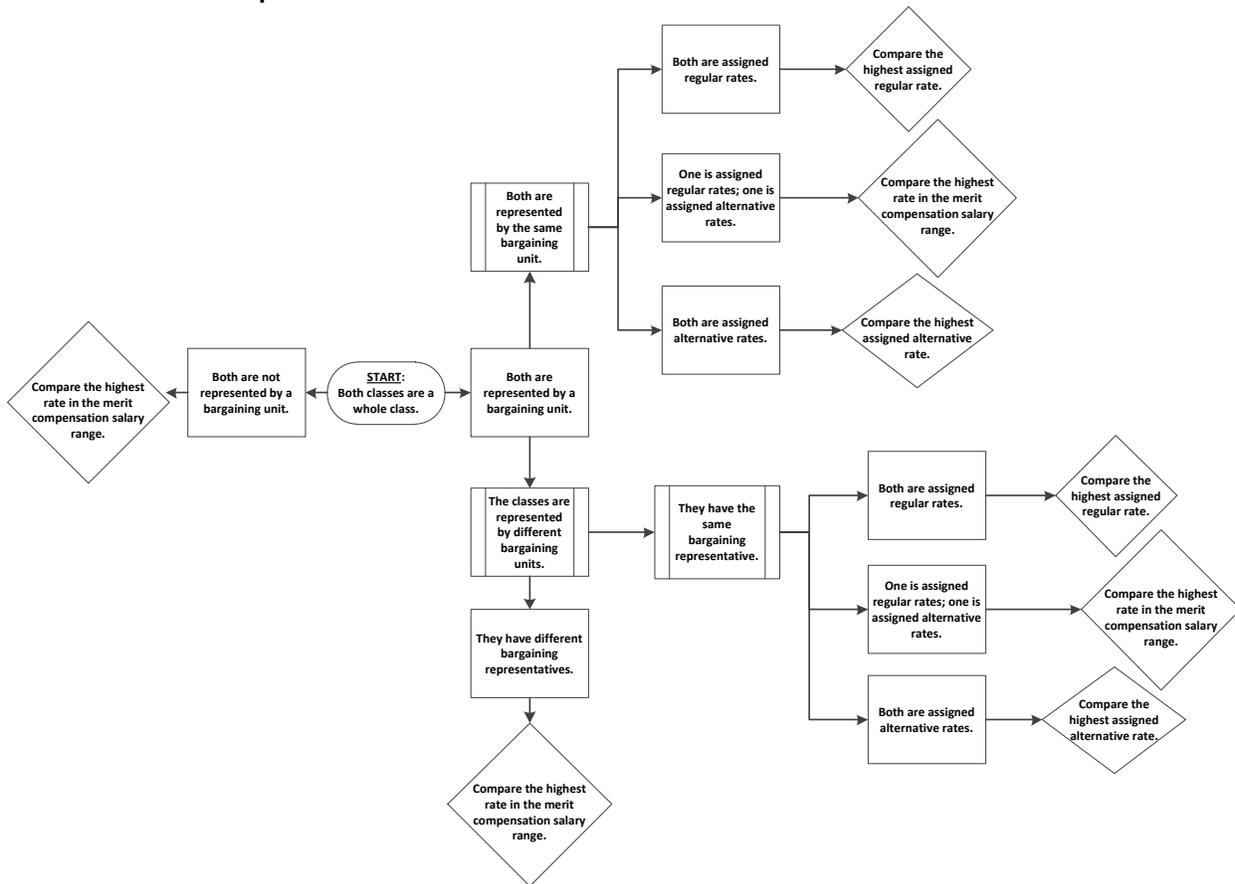
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX C Comparison of Pay Grade or Salary Ranges Assigned to Classifications~~Medical Administrator Rates (Repealed)~~**

**Section 310.ILLUSTRATION A Classification Comparison Flow Chart: Both Classes are Whole**

Classification Comparison Flow Chart: Both classes are whole.



(Source: Old Appendix C repealed at 32 Ill. Reg. 9881, effective July 1, 2008; new Appendix C added at 37 Ill. Reg. 9939, effective July 1, 2013)

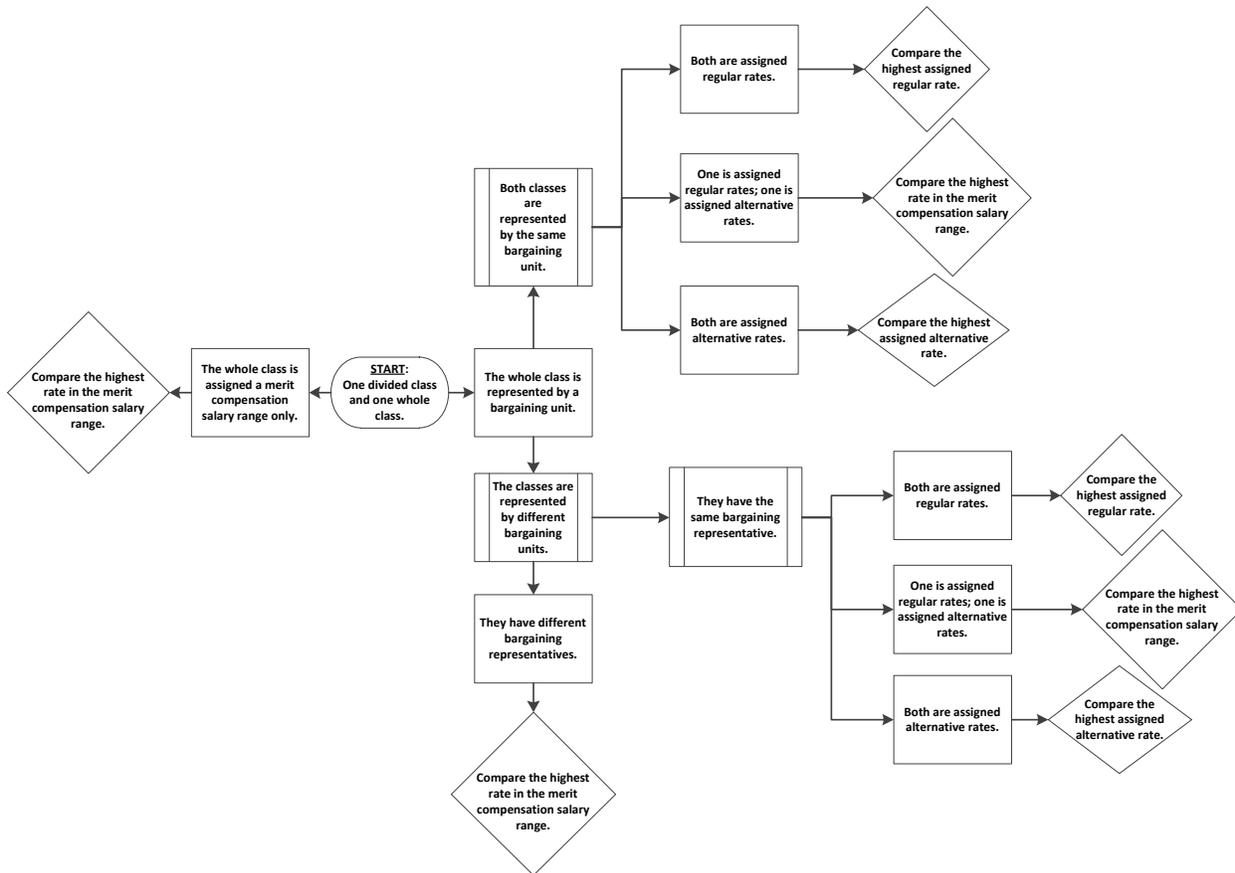
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX C Comparison of Pay Grade or Salary Ranges Assigned to Classifications**

**Section 310.ILLUSTRATION B Classification Comparison Flow Chart: One Class is Whole and One is Divided**

**Classification Comparison Flow Chart: One class is whole and one is divided.**



(Source: Old Appendix C repealed at 32 Ill. Reg. 9881, effective July 1, 2008; new Appendix C added at 37 Ill. Reg. 9939, effective July 1, 2013)

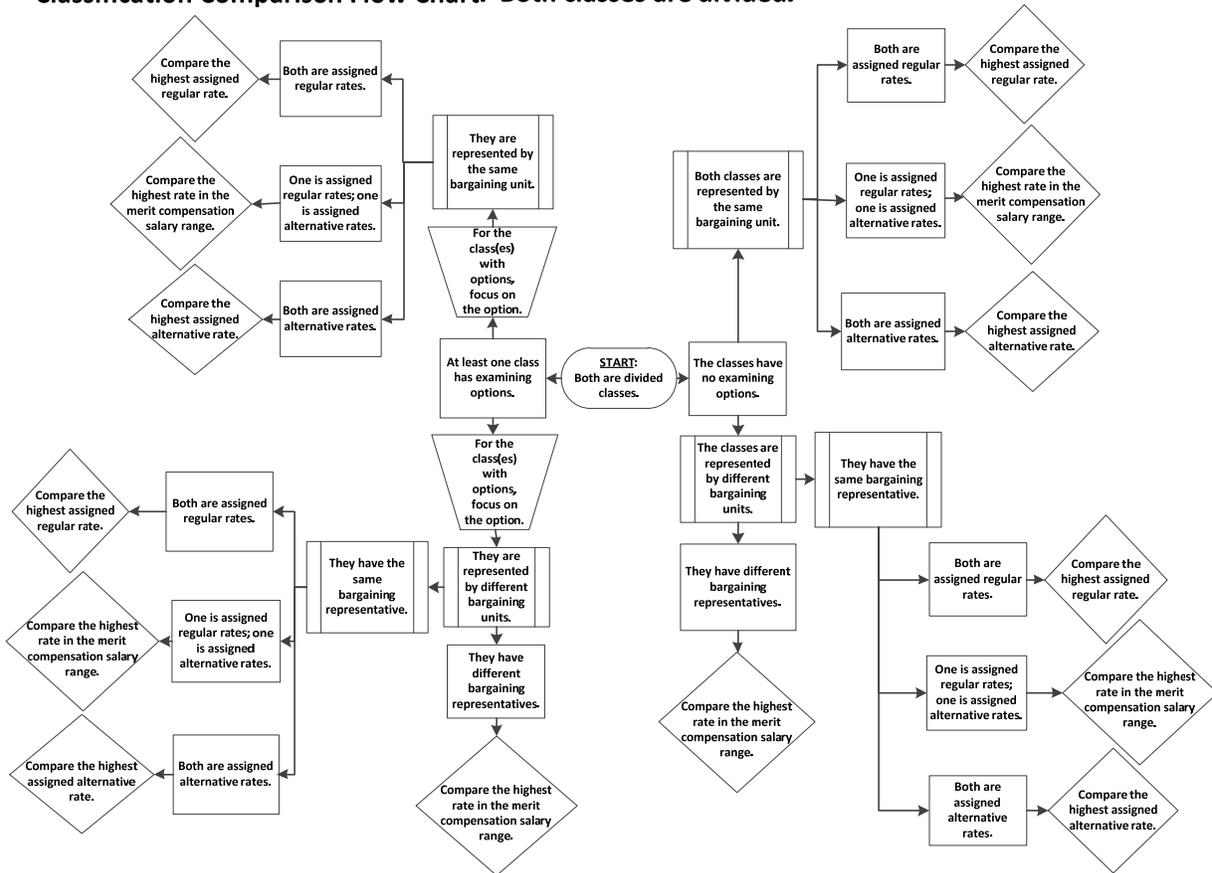
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

**Section 310.APPENDIX C Comparison of Pay Grade or Salary Ranges Assigned to Classifications**

**Section 310.ILLUSTRATION C Classification Comparison Flow Chart: Both Classes are Divided**

**Classification Comparison Flow Chart: Both classes are divided.**



(Source: Old Appendix C repealed at 32 Ill. Reg. 9881, effective July 1, 2008; new Appendix C added at 37 Ill. Reg. 9939, effective July 1, 2013)

## ILLINOIS COMMERCE COMMISSION

## NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Standards of Service Applicable to 9-1-1 Emergency Systems
- 2) Code Citation: 83 Ill. Adm. Code 725
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
725.100	Repeal
725.101	Repeal
725.105	Repeal
725.200	Repeal
725.205	Repeal
725.210	Repeal
725.215	Repeal
725.220	Repeal
725.225	Repeal
725.300	Repeal
725.305	Repeal
725.400	Repeal
725.500	Repeal
725.505	Repeal
725.600	Repeal
725.605	Repeal
725.610	Repeal
725.615	Repeal
725.620	Repeal
725.700	Repeal
725.810	Repeal
725.APPENDIX A	Repeal
- 4) Statutory Authority: Implementing and authorized by Section 10 of the Emergency Telephone System Act [50 ILCS 750/10]
- 5) Effective Date of Repealer: July 1, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted repealer is on file in the Commission's Springfield office and is available for public inspection.

## ILLINOIS COMMERCE COMMISSION

## NOTICE OF ADOPTED REPEALER

- 9) Notice of Proposal published in the *Illinois Register*: July 6, 2012; 36 Ill. Reg. 9493
- 10) Has JCAR issued a Statement of Objections to this Rulemaking? No
- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreement letter issued by JCAR? No agreements were necessary.
- 13) Will this rulemaking replace an emergency rulemaking currently in effect? No
- 14) Are there any proposed rulemakings pending on this Part? No
- 15) Summary and Purpose of Repealer: The Commission is concurrently adopting new rules at Part 725. The repealed rules are not reflective of advances in technology in telecommunications, nor are they reflective of changes in the Emergency Telephone System Act engendered by PA 96-25.
- 16) Information and questions regarding this adopted repealer shall be directed to:

Brian Allen  
Office of General Counsel  
Illinois Commerce Commission  
527 East Capitol Avenue  
Springfield, IL 62701

217/785-8439

## ILLINOIS COMMERCE COMMISSION

## NOTICE OF ADOPTED RULES

- 1) Heading of the Part: Standards of Service Applicable to 9-1-1 Emergency Systems
- 2) Code Citation: 83 Ill. Adm. Code 725
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
725.100	New Section
725.101	New Section
725.200	New Section
725.205	New Section
725.210	New Section
725.215	New Section
725.220	New Section
725.300	New Section
725.305	New Section
725.310	New Section
725.400	New Section
725.405	New Section
725.410	New Section
725.415	New Section
725.500	New Section
725.505	New Section
725.510	New Section
725.515	New Section
725.520	New Section
725.525	New Section
725.600	New Section
725.APPENDIX A	New Section
- 4) Statutory Authority: Implementing and authorized by Section 10 of the Emergency Telephone System Act [50 ILCS 750/10]
- 5) Effective Date of Rules: July 1, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rules is on file in the Commission's Springfield office and is available for public inspection.

## ILLINOIS COMMERCE COMMISSION

## NOTICE OF ADOPTED RULES

- 9) Notice of Proposal published in the *Illinois Register*: July 6, 2012, at 36 Ill. Reg. 9593
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: Section 725.10: Place definition "Access line" in alphabetical order.
- Section 725.10: Replace "'Geospatial"- Data accurately" with "'Geospatial data"- Accurately".
- Section 725.10: Definition "Master Street Address Guide": add "data" after "geospatial)"; delete ")" after "area"; replace "is to match" with "matches".
- Section 725.205(g): Replace originally-proposed language with adopted language.
- Section 725.500(e)(2)(C): Add "(Numbering Plan Area)".
- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes
- 13) Will this rulemaking replace an emergency rulemaking currently in effect? No
- 14) Are there any proposed rulemakings pending on this Part? No
- 15) Summary and Purpose of Rules? Recent amendments to the Public Utilities Act (PUA) have affected the provision of 9-1-1 services. PA 96-0025 enacted Section 13-900 of the PUA, creating a new certification category and authorizing the Commission to certify entities requesting to provide 9-1-1 services and operate as a "9-1-1 system provider". Prior to Section 13-900 becoming law, only incumbent local exchange carriers or certified telecommunication carriers could serve as 9-1-1 system providers. The new language allows new competitors that may not necessarily function as telecommunication carriers the ability to enter the 9-1-1 market with new and emerging 9-1-1 service technology. Furthermore, it allows the current incumbent local exchange carriers that have already been functioning in this capacity to be grandfathered in as 9-1-1 system providers.
- PA 96-0927 significantly amended the provisions of the PUA related to telecommunications. Among other changes, P.A. 96-0927 amends the PUA to add

## ILLINOIS COMMERCE COMMISSION

## NOTICE OF ADOPTED RULES

Section 13-401.1, which requires existing fixed or non-nomadic interconnected voice over Internet protocol (VoIP) providers to register with the Commission. According to the new law, existing fixed or non-nomadic interconnected VoIP providers were required to register no later than January 1, 2011. New fixed or non-nomadic interconnected VoIP providers are required to register at least 30 days before providing service in Illinois. In addition, PA 96-0927 adds a requirement in Section 13-401.1(b) of the PUA that the fixed or non-nomadic interconnected VoIP providers collect and remit 9-1-1 surcharges, in the same manner as telecommunications carriers providing local exchange service, to the local governmental 9-1-1 Emergency Telephone System Boards that authorize the use of such money to maintain 9-1-1 systems in those jurisdictions.

Previously, Part 725 did not allow for competition in 9-1-1 services offerings, nor did it contemplate the provisioning of Next Generation (NG9-1-1) or Internet Protocol (IP)-Enabled 9-1-1 services. The new rules will allow entities other than incumbent local exchange carriers or telecommunication carriers, the opportunity to become 9-1-1 system providers as provided by in Section 13-900 of the PUA. Additionally, the new rules will allow for other technological advancements to be introduced into 9-1-1. This is necessary so that the 9-1-1 systems in Illinois will have the ability to deploy a NG9-1-1 system which has become a national focus of the Federal Communications Commission. NG9-1-1, simply defined, is a system comprised of managed IP-based networks, gateways, other functional elements and databases that augment or replicate present day E9-1-1 features and functions and provide for new capacities. NG9-1-1 is designed to provide access to emergency services from all types of communication devices and provide multimedia data capabilities such as sending text and video to 9-1-1. The NG9-1-1 network also encourages improved interoperability between public safety agencies.

Additionally, new definitions needed to be added to Part 725 to address terms associated with NG9-1-1 so that Illinois' rules will be consistent with terms being used on a national level. This Part has also been reorganized to specifically define the roles and responsibilities of each party involved, i.e., the 9-1-1 authority, 9-1-1 system provider, PSAP, and telecommunication carriers. The rules address requirements in today's traditional telecommunication legacy environment as well as transitioning to a NG9-1-1 environment. Finally, the rules incorporate new program funding definitions/requirements imposed upon fixed or non-nomadic interconnected VoIP providers in Section 13-401.1 of the PUA.

- 16) Information and questions regarding this rulemaking shall be directed to:

Brian Allen

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ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED RULES

Office of General Counsel  
Illinois Commerce Commission  
527 East Capitol Avenue  
Springfield, IL 62701

217/785-8439

The full text of the Adopted Rules begins on the next page:

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TITLE 83: PUBLIC UTILITIES  
CHAPTER I: ILLINOIS COMMERCE COMMISSION  
SUBCHAPTER f: TELEPHONE UTILITIES

PART 725

STANDARDS OF SERVICE APPLICABLE TO 9-1-1 EMERGENCY SYSTEMS

SUBPART A: GENERAL PROVISIONS

Section

- 725.100 Application of Part
- 725.101 Definitions

SUBPART B: AUTHORIZATION TO OPERATE AS A 9-1-1 SYSTEM

Section

- 725.200 General Requirements
- 725.205 Tentative, Final or Modified Plans
- 725.210 Order
- 725.215 Records and Reports
- 725.220 Testing for Compliance with Technical and Operational Standards

SUBPART C: MANAGEMENT

Section

- 725.300 Management Systems
- 725.305 Commission Liaison
- 725.310 ETSB, Joint ETSB and Qualified Governmental Entities

SUBPART D: STANDARDS OF SERVICE

Section

- 725.400 9-1-1 Authority
- 725.405 9-1-1 System Provider
- 725.410 Telecommunications Carriers
- 725.415 Public Safety Answering Point

SUBPART E: OPERATIONS

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Section	
725.500	Testing Procedures
725.505	Call Handling Procedures
725.510	Electronic Communication Devices
725.515	Physical Security
725.520	9-1-1 Traditional Legacy Service Database
725.525	Call Boxes

## SUBPART F: SURCHARGE

Section	
725.600	Surcharge Administration and Monthly Report to the Emergency Telephone System Board

725.APPENDIX A Monthly Report to 9-1-1 Authority

**AUTHORITY:** Implementing and authorized by Section 10 of the Emergency Telephone System Act [50 ILCS 750/10].

**SOURCE:** Adopted at 4 Ill. Reg. 2, p. 163, effective December 31, 1979; amended at 5 Ill. Reg. 888, effective January 9, 1981; codified at 8 Ill. Reg. 12188; Part repealed, new Part adopted at 20 Ill. Reg. 5335, effective April 1, 1996; amended at 28 Ill. Reg. 15742, effective December 1, 2004; old Part repealed at 36 Ill. Reg. 10098, and new Part adopted at 37 Ill. Reg. 10100, effective July 1, 2013.

## SUBPART A: GENERAL PROVISIONS

**Section 725.100 Application of Part**

This Part shall apply to all public agencies, public safety agencies, public safety answering points, 9-1-1 authorities, 9-1-1 system providers and telecommunications carriers in the State of Illinois except to the extent of any exemptions conferred by law. This Part also pertains to 9-1-1 service regardless of the technology provisioned by the 9-1-1 system provider and 9-1-1 authority for the delivery of 9-1-1 service. This Part does not apply to a cellular or other mobile communication carrier as defined in Section 10 of the Wireless Emergency Telephone Safety Act [50 ILCS 751/10].

**Section 725.101 Definitions**

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In the interpretation of this Part, the following definitions shall be used.

*"9-1-1 system" – The geographic area that has been granted an order of authority by the Commission to use "9-1-1" as the primary emergency telephone number. [50 ILCS 750/2.19]*

"9-1-1 authority" – The ETSB or qualified governmental entity that provides for the management and operation of a 9-1-1 system within the scope of those duties and powers as are prescribed by the Emergency Telephone System Act (ETSA) [50 ILCS 750].

"9-1-1 system provider " – Any person, corporation, limited liability company, partnership, sole proprietorship, or entity of any description that acts as a 9-1-1 system provider within the meaning of Section 2.18 at the ETSA by contracting to provide 9-1-1 network and database services and who has been certified by the Commission pursuant to Section 13-900 of the Public Utilities Act [220 ILCS 5/13-900].

"9-1-1 telecommunications network" or "9-1-1 traditional legacy service" – An arrangement of channels, such as loops, trunks and associated switching facilities to exchange voice and data.

"Access line" – The connecting facility between a customer's premises network interface device and the local exchange carrier's facility that provides access to the switching network for local exchange and interexchange telecommunications service.

"Act" or "ETSA" – The Emergency Telephone System Act [50 ILCS 750].

"Adjacent agencies" – Any public or private safety agencies (police, firefighting, emergency medical and ambulance services or other emergency services) whose jurisdiction is outside the 9-1-1 system jurisdiction, but that is adjacent to or touches that 9-1-1 system's boundary.

"Aid Outside Normal Jurisdiction Boundaries Agreement" – A written cooperative agreement entered into by all participating and adjacent agencies and public safety agencies providing that, once an emergency unit is dispatched to a request through a system, that unit shall render its services to the requesting party

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without regard to whether the unit is operating outside its normal jurisdictional boundaries.

"Audible signal" – A buzzer, bell or tone device used to alert an individual that appropriate action is required.

*"Automatic alarm" or "automatic alerting device" – Any device that will access the 9-1-1 system for emergency services upon activation. [50 ILCS 750/2.14]*

"ALI" or "automatic location identification" – In an E9-1-1 system, the automatic display at the public safety answering point (PSAP) of the caller's telephone number, the address/location of the telephone and supplementary emergency services information.

"ANI" or "automatic number identification" – The automatic display of the 9-1-1 calling party's number on the PSAP monitor.

"Backup PSAP" – A public safety answering point that serves as an alternate to the primary PSAP for enhanced systems and is at a different location and operates independently from the primary PSAP. A backup PSAP may accept overflow calls from the primary PSAP or be activated in the event that the primary PSAP is disabled.

"Busy day" – A consecutive 24 hour period during which the greatest volume of traffic is handled in the central office.

"Busy hour" – The two consecutive half-hours each day during which the greatest volume of traffic is handled in the central office.

"Busy tone" – An audible signal indicating a call cannot be completed because the called access line is busy. The tone is applied 60 times per minute.

"Call box" – A device that is normally mounted to an outside wall of the serving telecommunications carrier central office and designed to provide emergency on-site answering by authorized personnel at the central office location in the event a central office is isolated from the 9-1-1 network.

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"Call referral" – A 9-1-1 service in which the PSAP telecommunicator provides the calling party with the telephone number of the appropriate public safety agency or other provider of emergency services.

"Call relay" – A 9-1-1 service in which the PSAP telecommunicator takes the pertinent information from a caller and relays that information to the appropriate public safety agency or other provider of emergency services.

"Call transfer" – A 9-1-1 service in which the PSAP telecommunicator receiving a call transfers that call to the appropriate public safety agency or other provider of emergency services.

"Central office" – The site where switching equipment is located. A local central office, also called an end office, is the switching office where individual subscriber's access lines appear. It houses the equipment that receives calls transmitted on the local loop and routes the call over the switched network either directly to the person called, if the call is placed to a location served by the same local central office, or to another central office, if the call is placed to a customer served by a different central office.

"Circuit" – The physical connection (or path) of channels, conductors and equipment between two given points through which an electronic or optical signal may be established.

"Commission" – The Illinois Commerce Commission.

"CPE" or "customer premises equipment" – Communications or terminal equipment located in the customer's facilities/terminal equipment at a PSAP.

"Default routing" – A feature that allows emergency calls to be routed to a designated default PSAP if the incoming emergency call cannot be selectively routed due to ANI failure, garbled digits or other causes that prevent selective routing.

"Direct dispatch" – A 9-1-1 service that provides for the direct dispatch by a PSAP telecommunicator of the appropriate unit upon receipt of an emergency call and the decision as to the proper action to be taken.

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"Diverse routing" – The practice of routing circuits along different physical or electrical paths in order to prevent total loss of 9-1-1 service in the event of a facility or hardware failure.

"E9-1-1 selective router" – A telecommunications carrier switching office or stand alone selective routing switch equipped with enhanced 9-1-1 service capabilities. This switch serves as an E9-1-1 selective router for emergency calls from other local offices in the 9-1-1 service area.

"Emergency call" – An emergency request for assistance made to a 9-1-1 system that requires immediate action to save a life, to report a fire, to stop a crime and/or to address any other situation as determined locally.

"Emergency service number" or "ESN" – Sometimes known as emergency service zone (ESZ). An ESN is a three to five digit number representing a unique combination of public safety agencies (police, fire and emergency medical service) designated to serve a specific range of addresses within a particular geographical area or ESZ. The term ESZ refers to the geographic area itself and is generally used only during the ESN definition process to label specific areas. The ESN facilitates the selective routing of calls to appropriate PSAPs in a traditional legacy 9-1-1 system.

"Emergency Telephone System Board" or "ETSB" – A board appointed by the corporate authorities of any county or municipality that provides for the management and operation of a 9-1-1 system within the scope of those duties and powers prescribed by ETSA. The corporate authorities shall provide for the manner of appointment, provided that members of the board meet the requirements of the statute.

"ELT" or "English language translation" – A database table that provides the names of the public safety agencies (or services) associated with an ESN/ESZ number that is displayed on the ALI screen at the PSAP.

"Enhanced 9-1-1" or "E9-1-1" – An emergency telephone system that includes dedicated network, selective routing, database, ALI, ANI, selective transfer, fixed transfer, and a call back number.

"Error ratio" – The percentage of database records that are not Master Street Address Guide valid for a specific 9-1-1 traditional legacy service system.

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"Exchange" – A unit established by a telecommunications carrier and approved by the Commission for the administration of telecommunications service in a specified geographical area. It may consist of one or more central offices together with associated plant used in furnishing telecommunications services in that area. Exchanges are identified on exchange boundary maps on file with the Commission.

"Exempt lines" – Lines other than those for which a 9-1-1 surcharge may be imposed under the criteria set forth in ETSA Section 15. Exempt lines include, but are not limited to, telecommunications carrier official lines and federal government lines.

"Fixed or non-nomadic interconnected" – An interconnected voice over Internet protocol service intended to be used at a fixed service location via a fixed broadband connection.

"Forced disconnect" – A feature that allows the PSAP to release a telephone connection, even though the calling party has not yet disconnected, to avoid caller jamming of the incoming trunks.

"Geospatial Data" – Accurately references to a precise location on the earth's surface using latitude, longitude, elevation and datum that identifies the coordinate system used.

"GIS" or "Geographical Information System" – A system for capturing, storing, displaying, analyzing and managing data and associated attributes that are spatially referenced.

*"Interconnected voice over Internet protocol provider" or "Interconnected VoIP Provider" –*

*Every corporation, company, association, joint stock company or association, firm, partnership, or individual, their lessees, trustees or receivers appointed by any court whatsoever that owns, controls, operates, manages, or provides within this State, directly or indirectly, Interconnected Voice over Internet Protocol Service VoIP service; or*

*The meaning prescribed in 47 CFR 9.3 [220 ILCS 5/13-234 and 13-235].*

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It is a service that:

Enables real-time, two-way voice communications;

Requires a broadband connection from the user's location;

Requires Internet protocol-compatible customer premises equipment;  
and

Permits users generally to receive calls that originate on the public switched telephone network and to terminate calls to the public switched network.

"IP" – Internet Protocol.

"IP gateway" – The point at which a circuit-switched call is encoded and repackaged into IP packets. Equipment that provides interconnection between two networks with different communications protocols.

"Local loop" – A channel between a customer's network interface and its serving central office. The most common form of loop, a pair of wires, is also called a line.

"Logging recorder" – A machine that records both sides of telephone and radio transmissions.

"Master Street Address Guide" or "MSAG" – The computerized geographical file that either consists of all street and address data or its functional equivalent (i.e., geospatial data) within the 9-1-1 system area. This database is the key to the selective routing capability of E9-1-1 systems. It matches an originating caller to a specific answering point based on the address data. The MSAG will require updating after the initial file is created.

*"Mechanical dialer" – A device that either manually or remotely triggers a dialing device to access the 9-1-1 system. [50 ILCS 750/2.15]*

"NENA" or "National Emergency Number Association" – The international not-for-profit organization whose purpose is to lead, assist and provide for the

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development, availability, implementation and enhancement of a universal emergency telephone number or system common to all jurisdictions through research, planning, publications, training and education.

*"Network connection" – A voice grade communication channel directly between a subscriber and a telecommunications carrier's public switched network, without the intervention of any other telecommunications carrier's switched network, that would be required to carry the subscriber's inter-premises traffic. The connection either is capable of providing access through the public switched network to a 9-1-1 system, if one exists; or if no system exists at the time a surcharge is imposed under Section 15.3 of ETSA, would be capable of providing access through the public switched network to the local 9-1-1 system if one existed. [50 ILCS 750/2.12(a)]*

"Network diagram" – A schematic flow chart that shows the actual network pieces and flow of activities in a picture.

"NG9-1-1" or "next generation 9-1-1 service" – A system comprised of managed IP-based networks, gateways, functional elements and databases that augment or replicate present day E9-1-1 features and functions and provide new capabilities. NG9-1-1 is designed to provide access to emergency services from all sources and to provide multimedia data capabilities for PSAPs and other emergency service organizations.

"On-line date" – A date that is agreed to by all parties as to when a 9-1-1 system is activated for the public.

"On-site database" – A copy of the database that resides with the local 9-1-1 authority.

"Operator services" – Any of a variety of telephone services that need the assistance of an operator or an automated "operator" (i.e., using interactive voice response technology and speech recognition). These services include collect calls, third party billed calls, and person-to-person calls.

"Order of authority" – A formal order of the Commission that authorizes public agencies or public safety agencies to provide 9-1-1 service in a geographical area.

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"OSP" or "originating service provider" – A communications provider that allows its users or subscribers to originate 9-1-1 voice or non-voice messages from the public to the 9-1-1 authority.

"Outbound Notification Systems" – A community outreach tool that automatically disperses information to the public and is not considered a function or part of a 9-1-1 system (see "System").

"Overflow" – A call or position used when a call is blocked or rerouted due to excessive traffic.

"P.01 grade of service" – The probability (P), expressed as a decimal fraction, of an emergency call being blocked. P.01 is the grade of service reflecting the probability that one call out of 100 during the average busy hour will be blocked. P.01 is the minimum recommended grade of service for 9-1-1 trunk groups.

"Primary point of contact" or "9-1-1 contact person" – The individual designated by the 9-1-1 authority as the contact point for the participating telecommunications carriers.

"PBX" or "Private branch exchange" – A private telephone system and associated equipment located on the user's property that provides communications between internal stations and external networks.

*"Public agency" – The State or any unit of local government or special purpose district located in whole or in part within this State that provides police, firefighting, medical or other emergency services or has authority to do so. [50 ILCS 750/2.01].*

"Public safety agency" – A functional division of a public agency that provides police, firefighting, medical or other emergency services.

"Public Safety Answering Point" or "PSAP" – The initial answering location of an emergency call.

"Public Utilities Act" – 220 ILCS 5.

"Rate center" – A geographically specified area used for determining mileage and/or usage dependent rates in the public switched network.

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"Secondary PSAP" – A location where an emergency call is transferred for dispatching purposes.

"Selective routing" – A system that automatically routes calls to predetermined PSAPs, based on the location of the calling telephone number.

"Service address" – The location of the primary use of the network connection or connections.

"Split exchange" – An exchange shared with more than one 9-1-1 system.

"Subscriptions" – A count of the maximum number of interconnected VoIP calls that an end-user may have active at the same time. If the interconnected VoIP provider's retail customer purchases a service (or services) that allow more than one interconnected VoIP call (excluding in-call features such as call waiting and three way calling) to be made from the customer's physical location at the same time, the number of subscriptions equals the maximum number of interconnected VoIP calls that the customer may have active at the same time. In the case of a business retail customer who purchases a service (or services) pursuant to a service agreement, the number of subscriptions equals the maximum number of interconnected VoIP calls that the customer may have active at the same time under the terms of the service agreements with that business customer.

"Surcharge" – An amount levied by the corporate authorities of any municipality or county on billed subscribers of network connections for installing and maintaining an Enhanced 9-1-1 system.

*"System" – The communications equipment required to produce a response by the appropriate emergency public safety agency as a result of an emergency call being placed to 9-1-1. [50 ILCS 750/2.06a]*

"System participants" – Any public or private safety agency (police, firefighting, emergency medical and ambulance services or other emergency services, pursuant to ETSA Section 4) whose jurisdiction is located within the 9-1-1 system boundaries.

"TDD" – A telecommunications device for the deaf. See "TTY."

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"Telecommunications carrier" – Shall have the same meaning as specified in Section 13-202 of the Public Utilities Act, including those carriers acting as resellers of telecommunications services. For the purpose of 9-1-1 service, this definition shall include telephone systems operating as mutual concerns. A telecommunications carrier under the Public Utilities Act may provide competitive or noncompetitive local exchange telecommunications services or any combination of the two as defined in Section 13-204 of the Public Utilities Act.

"Telecommunications service" – Shall have the same meaning as specified in Section 13-203 of the Public Utilities Act.

"Telecommunicator" – A person who is trained and employed in public safety telecommunications. The term applies to complaint telephone operators, radio operators, data terminal operators or any combination of these functions in a PSAP.

"Terminal equipment" – Telephone station apparatus.

"Transfer" – A feature that allows the PSAP telecommunicator to transfer emergency calls to a specific location or secondary PSAP.

"Trunk" – A transmission path between switching units, switching centers and/or toll centers.

"TTY" or "teletypewriter" – A telegraph device capable of transmitting and receiving alphanumeric information over communications channels and capable of servicing the needs of those persons with a hearing or speech disability.

"Uninterruptible power supply" – An emergency power source that can detect any change in power line frequency or voltage and automatically compensates for these changes by supplying additional power or converting to an auxiliary power source, without any loss of voltage or frequency.

"Virtual PSAP" – A fully functional worksite that is not bound to a specific location but is portable and scalable, connecting employees to the work process in the most advantageous setting, rather than employees having to come to a centralized work location to connect to the work process.

## SUBPART B: AUTHORIZATION TO OPERATE AS A 9-1-1 SYSTEM

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**Section 725.200 General Requirements**

- a) The digits "9-1-1" shall be the primary emergency telephone number within the system, but a public agency or public safety agency shall maintain a separate secondary 10 digit emergency backup number for at least six months after the 9-1-1 system is in operation and shall at all times maintain a separate number for non-emergency telephone calls.
- b) 9-1-1 service is a terminating only service that connects a person who has dialed the universal emergency service code 9-1-1 to the appropriate PSAP.
- c) Outbound notification systems used to notify the general public of a particular incident are not considered a part of a 9-1-1 "system" as defined in this Part.
- d) *The Emergency Telephone System Board in counties passing referendums and the Chairman of the County Board in counties implementing a 9-1-1 system shall be responsible to insure that all areas of the county are served. [50 ILCS 750/10.2]*
- e) Tentative, final and modified plans for 9-1-1 systems shall be filed in compliance with this Part and ETSA.
- f) Tentative plans shall be submitted to the Manager of the Commission's 9-1-1 Program or his or her designee for review as detailed in Section 725.205.
- g) Final plans shall be formally submitted to the Commission for approval as detailed in Section 725.205 and 83 Ill. Adm. Code 200 (Rules of Practice).
- h) A 9-1-1 system shall not become operational without an order of authority from the Commission.
- i) The following modifications to a 9-1-1 authority's existing 9-1-1 plan shall be formally submitted to the Commission for approval. These submissions shall include a modified plan, consisting of the revised application narrative and/or revised exhibits, as prescribed in Section 725.205. Modifications requiring Commission approval shall include:

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- 1) Changing boundaries that require an intergovernmental agreement between local governmental entities to exclude or include residents within the 9-1-1 jurisdiction;
  - 2) Consolidating or regionalizing two or more 9-1-1 systems by intergovernmental agreement into a joint 9-1-1 system;
  - 3) Contracting for dispatch services;
  - 4) Use of new technology (i.e., NG9-1-1);
  - 5) Changing or adding a 9-1-1 system provider;
  - 6) Changes in network configuration;
  - 7) Additions or changes of primary PSAPs; and
  - 8) Change of backup arrangement.
- j) The following modifications to a 9-1-1 authority's existing 9-1-1 plan need not be formally submitted to the Commission for approval. While Commission approval is not necessary for these modifications, the 9-1-1 authority must provide written notification and provide any new agreements to the 9-1-1 Program 10 business days prior to making the following changes:
- 1) Reductions/additions of secondary PSAPs;
  - 2) Reductions of primary PSAPs;
  - 3) Permanent relocation of a primary or backup PSAP facility;
  - 4) Reductions/additions of system participants or adjacent agencies.

**Section 725.205 Tentative, Final or Modified Plans**

- a) Tentative and final plans shall be filed in accordance to ETSA Section 11 and must conform to minimum standards as established pursuant to ETSA Section 10.

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- b) When a 9-1-1 system is initially established, a copy of the tentative plan for the system shall be submitted to the Manager of the Commission's 9-1-1 Program (or his or her designee) at least six months prior to the proposed on-line date. A copy of the tentative plan shall also be provided to the contracted 9-1-1 system providers. The Commission's 9-1-1 Program shall review each tentative plan and provide an opinion to the originating agency within 60 days after receipt.
- c) Once the tentative plan has been reviewed, a final plan shall be formally submitted to the Commission for approval no later than three months prior to the planned on-line date. A copy should also be provided to the 9-1-1 system providers.
- d) If any changes are made to an existing final plan, a modified plan must be formally submitted to the Commission for approval prior to any changes being allowed pursuant to an order of authority from the Commission.
- e) A tentative, final or modified plan must include a narrative of the proposed system's operation and design and a completed "Application to Illinois Commerce Commission for the Provision of 9-1-1 Service", consisting of the following exhibits:
  - 1) Exhibit 1: A map showing the boundaries of the proposed system;
  - 2) Exhibit 2: A map or maps showing the jurisdictional boundary of each system participant and adjoining public agencies and public safety agencies;
  - 3) Exhibit 3: A list of system participants showing the land area in square miles and the estimated population served in their jurisdictions, including their addresses, telephone numbers and form of dispatch;
  - 4) Exhibit 4: A list of the public agencies or public safety agencies adjacent to the proposed system boundaries, including their addresses and telephone numbers;
  - 5) Exhibit 5: A list of the telecommunications carriers and Interconnected VoIP providers who are known by the applicant to provide service within the jurisdiction of the 9-1-1 system;

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- 6) Exhibit 6: Identification of financial arrangements, including revenues available for funding the 9-1-1 system;
- 7) Exhibit 7: A summary of the anticipated implementation costs and annual operating costs of the proposed system that are directly associated with the emergency call handling process.
- 8) Exhibit 8: Call Handling Agreements: Copies of the proposed agreements between the PSAP and the public agencies and/or public safety agencies in a single system and copies of the proposed agreements between PSAPs in adjacent systems or, in the absence of a PSAP, the public agencies or public safety agencies whose jurisdictional boundaries are contiguous. These agreements shall indicate the primary and secondary methods to be employed for notification of emergency calls received from requesting parties within their respective jurisdictions and shall include direct dispatch, call referral, call relay or call transfer;
- 9) Exhibit 9: Aid Outside Normal Jurisdictional Boundaries: A copy of the proposed annual agreement between the PSAP management and all public agencies and/or public safety agencies in a single system and those in different systems whose jurisdictional boundaries are contiguous. This agreement shall provide that, once an emergency unit is dispatched in response to a request through the system by direct dispatch, call referral, call relay or call transfer, this unit shall render its service to the requesting party without regard to whether the unit is operating outside its normal jurisdictional boundaries. A copy of both agreements shall be filed with the Chief Clerk of the Commission at the time the petition is filed;
- 10) Exhibit 10: A network diagram and a test plan pursuant to Section 725.500(a) (completed to the extent possible in consideration of the tentative plan); and
- 11) Exhibit 11:
  - A) Contracts for dispatching services; intergovernmental agreements with the primary, back-up or secondary PSAPs for 9-1-1 services; and intergovernmental agreements for additional 9-1-1 services/and/or for the establishment of a Joint ETSB.

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- B) Contracts for service with 9-1-1 system providers. Parties to the contract may deem all or a portion of the contract to be proprietary and confidential.
- f) The advancement of modern communication technology used by consumers to access 9-1-1, as well as the creation of new and emerging 9-1-1 technology by new entrants serving as 9-1-1 system providers, has encouraged the development of a more advanced E9-1-1 system called NG9-1-1. Implementation of an NG9-1-1 system into the design of the 9-1-1 system will require the 9-1-1 authority to submit a final or modified plan to the Commission for approval. The following additional items must be included in the narrative of a NG9-1-1 final or modified plan:
- 1) Identify the 9-1-1 system providers. If multiple providers are being used, provide a detailed description of each provider's role;
  - 2) Explain the new system configuration and technological architecture (i.e., network and routing);
  - 3) Explain what national standards, protocols and/or operating measures will be followed;
  - 4) Explain what measures have been taken to create a robust, reliable and diverse/redundant network;
  - 5) Explain what functional elements and external interfaces will be needed for the NG9-1-1 system to supply data and assistance in processing an emergency call;
  - 6) Explain how the existing 9-1-1 traditional legacy wireline and wireless databases will interface and/or be transitioned into the NG9-1-1 system;
  - 7) Explain how these databases will be maintained and how address errors will be corrected and updated on a continuing basis. In addition, explain who will be responsible for updating and maintaining the data at a minimum on a daily basis Monday-Friday;
  - 8) Explain what quality of service standards will be followed to ensure the same level of quality for voice, 9-1-1 call setup time and ALI delivery for

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the proposed 9-1-1 system as compared to the 9-1-1 traditional legacy service;

- 9) Explain how new technology in the 9-1-1 system will co-exist with the 9-1-1 traditional legacy service;
  - 10) Explain what security measures will be placed on the IP 9-1-1 network and equipment to safeguard it from malicious attacks or threats to the system operation and what level of confidentiality will be placed on the system in order to keep unauthorized individuals from accessing it;
  - 11) Provide a detailed transition plan for the newly designed system;
  - 12) Provide a disaster recovery plan for system failures and outages;
  - 13) Provide a contingency plan in the event that the new system fails or the 9-1-1 system provider does not fulfill its obligation;
  - 14) Describe the financial and technical resources that the 9-1-1 authority needs in order to sustain such a system; and
  - 15) If migrating to a new technology, file a test plan that may vary from the existing testing requirements addressed in Section 725.500(a) given the technical differences in the service offering. The test plan must thoroughly explain how the operation of the network, routing and database accuracy will be verified.
- g) Unless either a hearing waiver is requested pursuant to subsection (h) or Staff of the Commission recommends approval of the Petition and there are no objections, the Commission shall hold hearings to review the final plan and shall either approve or deny the plan.
- h) The petitioner may request a hearing waiver. The hearing can be waived if requested by the petitioner and if neither Commission Staff nor any other party objects to the hearing waiver. The following procedures must be taken to request a waiver of the Commission's hearing process:
- 1) The waiver request shall be stated in the cover letter to the Chief Clerk and in the petition. Replacement language to be inserted as Item 1 in the

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petition shall be: "Review the final or modified plan based on the information submitted in the application and allow the parties involved to waive a hearing on the matter."

- 2) Publish a notice in local newspapers of general circulation at least 10 days prior to filing the application with the Commission. The notice shall appear in newspapers whose circulation covers all municipalities within the proposed system and those adjacent to the proposed system. A proof of publication from the newspapers shall be enclosed with the application.
- 3) Notify all system participants and adjacent agencies of the intent to file a plan with the Commission for a 9-1-1 emergency telephone system at least 10 days prior to filing the application with the Commission. This letter shall state petitioner's address and telephone number and the Commission's 9-1-1 Program address and telephone number for purposes of requesting additional information or submitting objections to the plan. Copies of these letters shall be attached to the submitted plan.
- 4) An affidavit from the serving 9-1-1 system provider that all information contained in the application is correct. The affidavit must be signed and notarized and submitted with the petition.
  - i) The Commission shall approve a final or modified plan when the petitioner has complied with the requirements of this Part and applicable laws.

**Section 725.210 Order of Authority**

- a) The 9-1-1 authority of a proposed 9-1-1 system shall file a petition for an order of authority to operate a 9-1-1 system as detailed and described in its final or modified plan. The final or modified plan shall be attached to the petition and filed with the Commission in accordance with the Commission's Rules of Practice (83 Ill. Adm. Code 200). The Commission will issue an order of authority authorizing the 9-1-1 authority to operate under the terms of its final or modified plan.
- b) Pursuant to ETSA, the Commission is authorized to set technical standards for the provisioning of 9-1-1 services throughout the State of Illinois. 9-1-1 authorities may only accept emergency calls routed to them through their 9-1-1 system

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providers who have been authorized by the Commission pursuant to Section 13.900 of the Public Utilities Act.

**Section 725.215 Records and Reports**

- a) The 9-1-1 authority shall maintain those records it considers necessary to document its operations and satisfy the requirements of interagency agreements. As a minimum, those records shall include:
  - 1) a log of major system operations;
  - 2) critical CPE or network outages; and
  - 3) records of telecommunications carrier database queries by the 9-1-1 authority.
- b) The records specified in subsection (a) shall be preserved for a minimum of one year.
- c) The 9-1-1 authority shall be required to file annually with the Commission's 9-1-1 Program, the Commission's Chief Clerk's Office and the Illinois Attorney General by January 31 the following items:
  - 1) the current 9-1-1 contact person for the 9-1-1 system;
  - 2) the current error ratio for the E9-1-1 traditional legacy service database as provided by the 9-1-1 system providers pursuant to Section 725.405(i)(6);
  - 3) the current surcharge rate being collected;
  - 4) the current makeup of the Emergency Telephone System Board and each board member's capacity (i.e., current public safety representative, public member, county board member, or elected official), as provided in ETSA Section 15.4 of the ETSA;
  - 5) a current network diagram for the 9-1-1 system as provided by the 9-1-1 system providers pursuant to Section 725.405(i)(7);

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- 6) copies of the annual certified notification of continuing agreement for all system participants and adjacent agencies;
- 7) current list of all system participants and adjacent agencies;
- 8) names and locations of primary, secondary and backup PSAPs; and
- 9) for the time period of January 1 through December 31 previous year, provide the following (if the 9-1-1 system is not capable of providing the data in this exact format due to the limitations of its statistical system, it must identify the problem in the report. When the system is upgraded, the upgrade must include the capability of providing the required data):
  - A) Total number of wireline and wireless 9-1-1 calls received annually; report separately if possible;
  - B) Total annual wireline surcharge received;
  - C) Total annual wireless surcharge received;
  - D) Total annual VoIP provider surcharge received;
  - E) Total annual 9-1-1 expenditures, including, but not limited to, PSAP equipment, network, database, switches, gateways, servers, maintenance, supplies, mapping, CAD, radio, building and personnel cost.

**Section 725.220 Testing for Compliance with Technical and Operational Standards**

The Commission shall have the authority to test 9-1-1 systems to verify compliance with technical and operational standards set forth in the Act and in this Part.

## SUBPART C: MANAGEMENT

**Section 725.300 Management Systems**

The form of management a system will use shall be determined by the 9-1-1 authority. There may be joint powers, contractual, or a combination of management forms.

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**Section 725.305 Commission Liaison**

Each 9-1-1 system shall designate an individual as the Commission liaison for the system. The Commission's 9-1-1 Program shall be notified of any change in the name of this liaison and of any change in the telephone number or address within 10 days after this change.

**Section 725.310 ETSB, Joint ETSB and Qualified Governmental Entities**

- a) *The corporate authorities of any county or municipality that imposes a surcharge shall establish an Emergency Telephone System Board. The corporate authorities shall provide for the manner of appointment and the number of members of the board, provided that the board shall consist of not fewer than 5 members, one of whom shall be a public member who is a resident of the local exchange service territory included in the 9-1-1 coverage area, one of whom (in counties with a population less than 100,000) must be a member of the county board, and at least three of whom shall be representatives of the 9-1-1 public safety agencies, including but not limited to police departments, fire departments, emergency medical services providers, and emergency services and disaster agencies and appointed on the basis of their ability and experience. Elected officials including members of a county board are also eligible to serve on the board. [50 ILCS 750/15.4(a)]*
- b) *Any two or more municipalities, counties, or combination thereof that impose a surcharge may, instead of establishing individual boards, establish by intergovernmental agreement a Joint Emergency Telephone System Board. The manner of appointment of such a joint board shall be prescribed in the agreement. The intergovernmental agreement must be consistent with subsection (a). The powers and duties of a joint board shall be defined by ordinance of the municipality or county or by intergovernmental agreement in the case of a joint board. [50 ILCS 750/15.4]*
- c) *Qualified governmental entity means a unit of local government authorized to provide 9-1-1 services pursuant to the Emergency Telephone System Act when no Emergency Telephone System Board exists. [50 ILCS 750/2.23]*

## SUBPART D: STANDARDS OF SERVICE

**Section 725.400 9-1-1 Authority**

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The 9-1-1 Authority:

- a) Shall obtain Commission authorization pursuant to Section 725.210, prior to operating a 9-1-1 system;
- b) Shall provide notification to Commission Staff within a minimum of 14 calendar days prior to 9-1-1 system activation;
- c) Shall provide continual review using recognized administrative, engineering, database and security procedures to assure adequate service to the general public in accordance with the Act and this Part;
- d) Shall comply with the provisions of all applicable federal or State laws regarding the provisioning of 9-1-1 services regarding wireline, wireless and VoIP or any other medium;
- e) Shall provide the overall management for the 9-1-1 system and all of its PSAPs and work in conjunction with the 9-1-1 system providers on the initial installation, continued maintenance, and any future modifications to the system;
- f) Shall enter into a service contract with one or more 9-1-1 system providers that have been authorized to operate in the State of Illinois pursuant to Section 13-900 of the Public Utilities Act to provide 9-1-1 database, call routing and other 9-1-1 duties and services associated with the 9-1-1 system that clearly delineates the responsibilities of the 9-1-1 system provider and 9-1-1 authority. A copy of this contract shall be filed with the final or modified plan to be approved by the Commission pursuant to Section 725.205. Parties to the contract may deem all or a portion of the contract as proprietary and confidential;
- g) Shall ensure that contracts with multiple 9-1-1 system providers clearly define the role of each 9-1-1 system provider as it relates to its responsibility for providing database, routing of emergency calls and the building of the 9-1-1 network. The 9-1-1 authority shall coordinate the tasks between 9-1-1 system providers;
- h) Must maintain data in the MSAG or its functional equivalent for those 9-1-1 systems employing new and emerging technology;
- i) Shall develop and utilize written 9-1-1 Standard Operating Procedures (SOPs) of its operations for use by its telecommunicators and supervisory personnel (i.e.,

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call trace for basic systems, service restoration/equipment failure, and disaster procedures in the event that critical functions of the PSAP are partially or totally disabled). Each PSAP shall be given a copy of the 9-1-1 SOPs that shall be kept on file at each PSAP;

- j) Shall ensure that civic 9-1-1 locatable addresses, with U.S. Postal Service approval, are assigned to all subscribers with a static address and provided to the 9-1-1 system provider;
- k) Shall coordinate with the appropriate authorities to ensure that road or street signs that are essential to the implementation of an enhanced 9-1-1 system will be installed prior to activating the system;
- l) Shall accept all OSP end user emergency calls from its 9-1-1 system provider as long as it is technically feasible regardless of the technology employed in generating the emergency call. The 9-1-1 authorities may only accept emergency calls routed into their system from a certified 9-1-1 system provider; and
- m) Shall ensure that emergency calls are not routed or transferred to an automated attendant or automated voice response system.

**Section 725.405 9-1-1 System Provider**

A 9-1-1 System Provider:

- a) Shall be certified under Section 13-900 of the Public Utilities Act as a 9-1-1 system provider prior to entering into any contract with a 9-1-1 authority to provide 9-1-1 services;
- b) Shall file tariffs under Sections 13-900.1 and 9-102 of the Public Utilities Act for 9-1-1 services prior to offering such services;
- c) Shall enter into a service contract with each 9-1-1 authority for which it plans to provide 9-1-1 database, call routing and other 9-1-1 duties and services associated with the 9-1-1 system that clearly delineates the responsibilities of the 9-1-1 system provider and 9-1-1 authority;
- d) Shall assume the lead role in coordinating the implementation of the 9-1-1 project. The 9-1-1 system provider is responsible for the initial implementation

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and mutually agreed upon changes/modifications, project timeline, milestone progress report/conference calls with Commission 9-1-1 Program Staff and all involved parties. If there are multiple 9-1-1 system providers, the 9-1-1 authority shall specify the role of each provider pursuant to Section 725.400(g);

- e) Shall comply with any provisions of all applicable federal or State laws regarding the provisioning of 9-1-1 services regarding wireline, wireless and VoIP or any other medium;
- f) Shall comply with back-up power requirements for 9-1-1 equipment and facilities as specified in 83 Ill. Adm. Code 730.325;
- g) Shall comply with physical security requirements for its facilities as specified in 83 Ill. Adm. Code 785.35;
- h) Shall provision "9-1-1 Service" in one of the following types:
  - 1) Basic 9-1-1 service is an emergency telephone system that automatically connects 9-1-1 callers to a designated answering point through either dedicated direct trunking and/or tandem trunking from the central office to the PSAP. Basic 9-1-1 does not typically support ANI and ALI. The features associated with basic service shall be according to the following format types:
    - A) Type #1 – This is the most basic configuration available and provides:
      - i) no per-call charge;
      - ii) loop-type ringdown signaling toward PSAP;
      - iii) ringback tone to caller; and
      - iv) transmission path for communication between the caller and the PSAP;
    - B) Type #2 – This configuration provides all the features of the Type #1 circuit with the following options:

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- i) called party hold;
  - ii) forced disconnect;
  - iii) idle circuit tone application; and
  - iv) originating switchhook status indication contingent on the installation of appropriate terminal equipment at the PSAP;
- C) Type #3 – This configuration provides all the features of the Type #1 and Type #2 circuits with the addition of ringback of the calling party on a held line;
- D) Type #4 – This configuration provides for optional features beyond those described in the configuration of Type #2 or Type #3. This type of Basic 9-1-1 also requires trunks capable of carrying ANI.
- 2) E9-1-1 service is a system that includes a dedicated network, selective routing, and a database that interfaces with a PSAP CPE capable of receiving and providing ANI and ALI. It can be provisioned through either a 9-1-1 telecommunications network that is commonly referred to as "9-1-1 traditional legacy service" or a 9-1-1 IP network which is commonly referred to as "NG9-1-1 service":
- A) 9-1-1 traditional legacy service: Provides the capability to serve several PSAPs existing within the 9-1-1 service area with tandem trunking through the E9-1-1 selective router. The main features of E9-1-1 service is the capability of the E9-1-1 selective router to selectively route an emergency call originating from any station in the 9-1-1 service area to the correct primary PSAP. The features associated with tandem trunking in an E9-1-1 system may include the following:
- i) Selective routing;
  - ii) Default routing;
  - iii) Alternate routing;

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- iv) Transfer capabilities;
  - v) Forced disconnect;
  - vi) No per call charge;
  - vii) ANI; and
  - viii) ALI.
- B) NG9-1-1 service provides the capability to serve several PSAPs existing within the 9-1-1 service area through an IP network. The main feature of NG9-1-1 service is the capability to route an emergency call originating from multiple types of technology capable of calling 9-1-1. The capabilities and features associated with NG9-1-1 may include but are not limited to the following:
- i) IP gateway;
  - ii) Geospatial routing;
  - iii) Default routing;
  - iv) Alternate routing;
  - v) Transfer capabilities;
  - vi) ANI;
  - vii) ALI; and
  - viii) Transmit data and/or text and/or video with the emergency call when feasible and/or available.
- C) Any combination of subsections (h)(2)(A) and (B).
- i) The 9-1-1 system provider shall meet the following technical requirements for the provisioning of 9-1-1 service:

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- 1) Utilizing mutually acceptable and agreed upon standards for database record exchange as prescribed, at a minimum, by the National Emergency Number Association in "NENA, Standard Data Formats For ALI Data Exchange, MSAG & GIS Mapping" (NENA 02-010, v9, 3/28/2011; this incorporation includes no later amendments or editions).
- 2) Obtaining, maintaining and updating end user subscriber information provided by all participating OSPs in order to maintain the 9-1-1 database to meet the requirements set forth in ETSA Section 15.4(d).
- 3) Creating, maintaining and updating the MSAG and database, GIS database, or functional equivalent in conjunction with the 9-1-1 authority and all OSPs.
- 4) Updating the ALI database on a daily basis during normal business days.
- 5) Providing notification of errors to the appropriate entities within 24 hours for corrective action.
- 6) Providing the error ratio to the 9-1-1 authority no later than December 31 of each year. 9-1-1 authorities may request the percentage on a more frequent basis, but not more than once a month.
- 7) Providing a network diagram to the 9-1-1 authority, annually within the 4<sup>th</sup> quarter of each year, no later than December 31. Additionally, updated diagrams must be provided to the 9-1-1 authority when a modification is required to be filed with the Commission.
- 8) Coordinating the development and the maintenance of the 9-1-1 database with all participating OSPs and the 9-1-1 authority and ensure that all required information for routing tables, i.e., NPA/NXX, ESN, default ESN, PANIs and any other items that may become necessary for the functionality of maintaining an accurate database and/or routing tables, is obtained.
- 9) Coordinating the installation of all network components with all participating OSPs and/or third party provider who may connect its network and transport 9-1-1 traffic to the appropriate 9-1-1 system provider on behalf of an OSP. In these cases, the OSP, the 9-1-1 system

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provider, and the third party telecommunications carrier shall work cooperatively with the 9-1-1 authority to ensure that appropriate default routes are chosen and proper network congestion control measures are maintained. The network design must adhere to the default routing and acceptable engineering practices as specified in subsections (h)(11) and (22).

- 10) Routing all emergency calls from any OSP without discrimination where technically feasible.
- 11) Provisioning all 9-1-1 facilities over dedicated redundant facilities. This should be considered to be the standard method of providing all incoming 9-1-1 facilities and, where possible, employ diverse routing. 9-1-1 circuits and facilities shall be sufficient to complete 99% of all emergency calls during the average busy hour of the average busy day. In all cases, the 9-1-1 network shall be provisioned to handle a minimum of two circuits and/or simultaneous calls, and shall use dedicated, diverse and/or redundant equipment, where available, in order to increase the survivability of the 9-1-1 network. Additionally the Commission 9-1-1 Program Staff and or 9-1-1 authority may on an annual basis or in the event of a problem request traffic studies be performed or other documentation be provided to verify that the standard is being met.
- 12) Provisioning 9-1-1 facilities for one way incoming only service to the PSAP. Origination of outbound dialing on 9-1-1 circuits without a caller or active 9-1-1 call on the circuit is prohibited.
- 13) Provisioning the transmission grade of service for 9-1-1 facilities using inter-exchange facilities equivalent to those specified in 83 Ill. Adm. Code 730.520.
- 14) Provisioning the transmission grade of service for the intra-exchange loop portion of any 9-1-1 facilities equivalent to those specified in 83 Ill. Adm. Code 730.525.
- 15) Notifying the 9-1-1 authority a minimum of 48 hours prior to performing any planned activities that could adversely affect 9-1-1 service.

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- 16) Adopting practices to minimize the possibility of service disruption on all facilities associated with 9-1-1 service to a PSAP prior to 9-1-1 going on line.
- 17) Maintaining a contact number for notifying the appropriate 9-1-1 authority in the event of an outage or failure of a 9-1-1 system.
- 18) Notifying a primary point of contact within a 9-1-1 system within 15 minutes after detecting a confirmed outage within the system and advising the primary point of contact as to the magnitude of the outage once fully known. In addition, the 9-1-1 system provider must notify the Commission's 24 hour emergency number (217-558-6166) pursuant to 83 Ill. Adm. Code 730.550.
- 19) Notifying a primary point of contact of a 9-1-1 system and the Commission's 24 hour emergency number (217-558-6166) pursuant to 83 Ill. Adm. Code 730.550 within 15 minutes after the confirmed restoration of 9-1-1 services.
- 20) Delivering 9-1-1 service elements for the provisioning and ongoing maintenance of the 9-1-1 systems as follows:
  - A) Provide database coordination with all participating OSPs when applicable.
  - B) Provide network coordination with all participating OSPs when applicable.
  - C) Provide maintenance and repair procedures, service and repair center contact information, a restoration plan and call trace procedures to the 9-1-1 authority.
- 21) Adopting practices and implementing procedures to reduce or minimize the conditions that cause default routed calls.
- 22) Default routing, at a minimum, by county. Where an exchange boundary/rate center crosses county boundaries, the 9-1-1 system provider may establish a single default with the approval of the 9-1-1 authority for those affected 9-1-1 systems.

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- 23) Adopting practices to provide the appropriate services to Private Business Switch and Private Residential Switch subscribers for the purposes of complying with ETSA Sections 15.5 and 15.6 and 83 Ill. Adm. Code 726.
- 24) Providing the 9-1-1 authority with the information, reports or other documents required, to enable the 9-1-1 authority to complete its annual filings to the Commission.
- 25) Cooperating with other 9-1-1 system providers to hand off split exchange subscribers to another 9-1-1 system provider in a mutually acceptable manner and in accordance with good engineering design and standards.
- 26) Cooperating with other 9-1-1 system providers in the installation of a new 9-1-1 system or migration of a system from another 9-1-1 system provider.

**Section 725.410 Telecommunications Carriers**

- a) Each telecommunications carrier shall file tariffs under Section 13-900.1 of the Public Utilities Act for 9-1-1 telecommunications service to be applied to all services specific to 9-1-1 installations on the carrier's network side of the customer demarcation point.
- b) Dedicated redundant facilities should be considered to be the standard method of providing all incoming 9-1-1 facilities and, when possible, employ diverse routing. 9-1-1 circuits and facilities shall be sufficient to complete 99% of all requests for emergency services during the average busy hour of the average busy day. In all cases, the 9-1-1 network shall be provisioned to handle a minimum of two circuits and/or simultaneous calls, and shall use dedicated, diverse and/or redundant equipment, when available, in order to increase the survivability of the 9-1-1 network. Additionally, the Commission 9-1-1 Program Staff and/or 9-1-1 authority may, on an annual basis or in the event of a problem, request traffic studies or other documentation to verify that the standard is being met.
- c) Coin-free dialing of the digits 9-1-1 shall be provided from all coin telephones within an exchange with 9-1-1 service.

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- d) The transmission grade of service on 9-1-1 facilities using inter-exchange facilities shall be at least equivalent to the transmission grade of service specified in 83 Ill. Adm. Code 730.520 dealing with interoffice transmission objectives.
- e) The transmission grade of service for the intra-exchange loop portion of any 9-1-1 facilities shall be at least equivalent to the transmission grade of service specified in 83 Ill. Adm. Code 730.525 dealing with local loop transmission objectives.
- f) When all 9-1-1 facilities are busy in the originating central office, the switching facility, when equipped to provide the function, shall route the caller to an announcement or busy tone. When an all trunks busy situation occurs in an intermediate switching facility, that switch shall, when equipped, route the caller to an appropriate backup or alternate answering location, announcement, or busy tone.
- g) All telecommunications carriers shall arrange for each of their switching offices to accept the 9-1-1 code.
- h) Telecommunications carrier personnel shall notify the 9-1-1 authority a minimum of 48 hours prior to performing any planned action that could adversely affect 9-1-1 service.
- i) Each telecommunications carrier shall adopt practices to minimize the possibility of service disruption on all facilities associated with 9-1-1 service to a 9-1-1 system. These practices will provide for facility guarding at all terminations with protective devices that will minimize accidental worker caused service interruption. These practices shall also contain procedures for physical identification of all 9-1-1 facilities with special warning tags and/or labels and identification of circuits in company records.
- j) Each telecommunications carrier shall deliver 9-1-1 service elements for the provisioning and ongoing maintenance of the 9-1-1 systems as follows:
  - 1) Collect and remit the appropriate 9-1-1 surcharge for each 9-1-1 authority mandated by statute and local referendum, excluding the 3% collection fee.
  - 2) Provide database downloads and updates to the appropriate 9-1-1 system provider for each 9-1-1 system in which it has subscribers.

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- 3) Adhere to acceptable and agreed upon standards for database record exchange as prescribed, at a minimum, by NENA Standard Data Formats For ALI Data Exchange, MSAG & GIS.
- 4) Process error corrections within 2 business days after receipt of an error report from the 9-1-1 system provider and/or 9-1-1 authority.
- 5) Provision and connect its network to the appropriate 9-1-1 system provider. Nothing in this Section prohibits a telecommunications carrier from contracting with a third party provider who may connect its network to the appropriate 9-1-1 system provider for the transport of 9-1-1 traffic. The network design must adhere to the engineering practices and default routing requirements specified in Section 725.405(i)(11) and (22).
- 6) Not deliver emergency calls to operator services.
- 7) Provide maintenance and repair procedures, service and repair center contact information, maintain a restoration plan and perform call trace procedures to the 9-1-1 authority.
- 8) Comply and arrange for default routing requirements with the 9-1-1 system provider and the 9-1-1 authority.
- 9) Maintain a list of contact numbers for notifying the appropriate 9-1-1 system in the event of an outage or failure of a 9-1-1 system.
- 10) Notify a primary point of contact for the 9-1-1 authority within 15 minutes after a confirmed outage within the system and also advise the primary point of contact as to the magnitude of the outage. In addition, the telecommunications carrier must notify the Commission's 24 hour emergency outage number (217-558-6166) pursuant to 83 Ill. Adm. Code 730.550.
- 11) Shall notify a primary point of contact with the 9-1-1 authority and the Commission's 24 hour emergency outage number (217-558-6166) pursuant to 83 Ill. Adm. Code 730.550 within 15 minutes after the confirmed restoration of 9-1-1 services.

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- 12) Cooperate with 9-1-1 system providers to assist in terminating split exchange traffic between 9-1-1 systems.
- 13) Cooperate with 9-1-1 system providers in the installation of a new 9-1-1 system or migration of an existing 9-1-1 system to another 9-1-1 system provider.
- k) Each telecommunications carrier shall adopt practices and procedures to deliver emergency calls to the appropriate 9-1-1 system provider.

**Section 725.415 Public Safety Answering Point**

- a) All 9-1-1 CPE used by a PSAP must be compatible with the 9-1-1 system provider's equipment and transport arrangements.
- b) Each PSAP, after consultation with the 9-1-1 system provider, shall designate an area of adequate size to be used by the 9-1-1 system provider for termination of the company's lines and equipment.
- c) The CPE shall indicate incoming calls by both audible and visible signals for each 9-1-1 circuit. Each outgoing circuit shall have a visual display of its status.
- d) Each 9-1-1 answering position shall have access to all incoming 9-1-1 circuits and outgoing circuits.
- e) The CPE shall be designed to achieve transfers with at least 99.9% completion. This may require the use of dedicated facilities between the PSAPs. When the telecommunicator verifies that the transfer has been completed and the telecommunicator's services are no longer required, the telecommunicator may manually release himself/herself from the emergency call, provided that the CPE is so designed. A 9-1-1 system should be designed so that an emergency call will never be transferred more than once; however, there could be circumstances beyond the PSAP's control that might warrant more than one transfer.
- f) Each answering position shall have direct access to an operational teletypewriter or its equivalent, and all PSAP telecommunicators shall be trained in its use at least every six months. The 9-1-1 authority will ensure that TTY equipment or its equivalent is available to continue service in the event of emergency, malfunction or power failure.

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- g) At a minimum each PSAP shall have at least two fully equipped answering positions. The staffing levels and the number of positions beyond this requirement shall be determined by the 9-1-1 authority based on call volume and average length of calls (i.e., if PSAP is responsible for EMD, call processing could take longer and require additional telecommunicators). Overflow emergency calls shall be routed to a backup PSAP as provided for in subsection (i).
- h) The 9-1-1 authority is responsible for ensuring that its primary, back-up and secondary PSAPs provide continuous and uninterrupted operation 24 hours per day, 7 days a week.
- i) Backup PSAP
- 1) Each 9-1-1 system shall have a backup PSAP that must operate independently from the primary PSAP. The backup PSAP must have the capability to dispatch (by either direct, transfer or call relay methods) the appropriate public safety agencies for that 9-1-1 system. A backup PSAP shall meet the same standards as the primary PSAP, except as provided for in subsection (i)(2).
  - 2) In a 9-1-1 system with a population of less than 10,000, when the system has demonstrated that the requirements of subsections (h) and (i) would place an undue financial burden upon the system, the 9-1-1 authority can ask the Commission for an exemption from having a full feature manned backup PSAP. A 9-1-1 system operating under this exemption should, as funds become available, upgrade its backup PSAP capability to meet those standards specified in subsections (g), (h) and (i)(1). If the system ever exceeds 5,000 billable access lines for a period of one year, it shall upgrade to meet the standards specified in subsections (g), (h) and (i)(1). For those systems operating under this exemption, some alternative form of back-up shall be required. The backup PSAP requirement may be met by one of the following:
    - A) An unattended PSAP shall have:
      - i) the capability to provide 9-1-1 service;

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- ii) the communication equipment necessary to dispatch emergency services;
  - iii) a backup power supply;
  - iv) the ability to communicate via TTY; and
  - v) the capability to be immediately activated with authorized and trained personnel.
- B) Some other method that the 9-1-1 authority must be able to demonstrate, in its request for an exemption, would meet the public safety needs of its community by being able to take 9-1-1 calls and dispatch them successfully on a temporary basis in an emergency situation.
- j) The use of virtual PSAPs may be acceptable; however, this must be included as a part of the 9-1-1 system final or modified plan authorized by the Commission.
- k) PSAP telecommunicators shall be trained in emergency dispatch procedures and 9-1-1 SOPs as specified by the 9-1-1 authority to fulfill the responsibilities of their position, with the following requirements:
- 1) Newly hired telecommunicators must receive, at a minimum, an 80-hour training curriculum approved by the 9-1-1 authority prior to handling emergency calls.
  - 2) If emergency medical dispatch is being provided that involves the dispatch of any fire department or emergency medical service agency, additional training must be completed in accordance to the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] and 77 Ill. Adm. Code 515 in addition to the 80-hour minimum.
  - 3) Continuing education for existing telecommunicators is required in all aspects of emergency call handling and will be specified by the 9-1-1 authority.
- l) The 9-1-1 authority shall provide for the installation of a master logging recorder of adequate capacity to record both sides of a conversation of each incoming

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emergency call and any radio transmissions relating to the emergency call and its disposition for each PSAP (primary, backup and secondary PSAPs). These recordings shall have the time of each event noted. The 9-1-1 authority may elect to record on a circuit-by-circuit basis or by way of the telecommunicator's position.

- m) The 9-1-1 authority shall ensure that each PSAP (primary, backup and secondary) maintains an archive of the storage media for a minimum of 90 days without recirculation of any media.
- n) Where CPE is implemented and is not tolerant of power fluctuations or interruptions, and is vital to the PSAP's operation, an uninterruptible power supply shall be installed at all PSAP locations (primary, backup and secondary) for continuous operation.
- o) All PSAP locations (primary, backup and secondary), must be equipped with an emergency back-up power source capable of supplying electrical power to serve the basic power requirements of the PSAP, without interruption, for longer outage times frames. It shall provide a minimum of four hours of power. The back-up power source shall be tested for reliability on a monthly basis.
- p) Each PSAP shall have at least one 24 hour staffed telephone number to be provided to telecommunications carrier operators, adjacent PSAPs and public safety agencies in order to communicate with that PSAP.
- q) PSAP employees shall be instructed to be efficient and courteous in the handling of all emergency calls and to comply with the provisions of all applicable federal and State laws in maintaining secrecy of communications.
- r) Each PSAP shall insure that all emergency calls are answered and handled without preference to the location of the caller.
- s) Each PSAP should answer 90% of all emergency calls within 10 seconds.
- t) All calls of an administrative or non-emergency nature shall be referred to the appropriate agency's published telephone number.
- u) A current copy of the 9-1-1 authority's SOPs shall be on file in every PSAP.

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## SUBPART E: OPERATIONS

**Section 725.500 Testing Procedures**

- a) The 9-1-1 authority will prepare a written test plan that will be submitted as Exhibit 10 in the final plan pursuant to Section 725.205 to be filed with the Commission. The test plan will explain how the 9-1-1 authority plans to perform its testing in conjunction with the 9-1-1 system providers and telecommunications carriers.
- b) The 9-1-1 authority shall ensure that proper field testing has been performed on a minimum of 40% of all access lines in the 9-1-1 service area. It shall include each NXX for every telecommunications carrier and for every ESN within each service area prior to the 9-1-1 system being able to announce its availability to the public.
- c) Each 9-1-1 system provider and telecommunications carrier will work with the 9-1-1 authority to ensure that call through testing and data verification of over 40% of subscribers from all areas, prefixes, carriers and types of services in their system are completed before allowing the 9-1-1 service to go live or to transition from one 9-1-1 system provider to another.
- d) The 9-1-1 system provider may not cut the 9-1-1 system live until the 9-1-1 traditional legacy service database is at a 1% or less error ratio pursuant to ETSA Section 15.4(d). Errors found during testing shall be corrected prior to cutting the system live.
- e) The 9-1-1 authority is responsible for ongoing testing once the 9-1-1 system is on-line and shall, at a minimum, include the following:
  - 1) The 9-1-1 authority shall conduct testing, including, but not limited to, the 9-1-1 database, networking, system overflow, system backup, default routing, and call transfer on a continuing basis to ensure system integrity. The testing shall be coordinated in advance and in conjunction with the 9-1-1 system provider and telecommunications carriers.
  - 2) The 9-1-1 authority and 9-1-1 system providers shall participate in coordinated testing with the telecommunications carriers when any of the following occur:

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- A) New central office switching installations;
  - B) E9-1-1 selective router or functional equivalent installations, upgrades or rehomes;
  - C) NPA (Numbering Plan Area) additions;
  - D) Migration from one 9-1-1 system provider to another; and
  - E) Any other event that affects 9-1-1.
- 3) Upon request, after notification of implementation, the 9-1-1 authority shall perform coordinated testing with the private residential or business switch operators.
  - 4) The 9-1-1 authority in conjunction with the telecommunications carriers shall test all call boxes annually, at a minimum, and keep a running log of the testing.

**Section 725.505 Call Handling Procedures**

- a) The 9-1-1 authority shall insure that the disposition of each emergency call is handled according to the agreements it has negotiated with its system participants and adjacent agencies in Exhibit 3 and Exhibit 4 of its final plan (see Section 725.205).
- b) Certified notification of the continuing agreements shall be made among the involved parties on an annual basis pursuant to ETSA Section 15.
- c) In instances in which a selected agency refuses a 9-1-1 request on the basis that a request is outside its jurisdictional boundaries, the telecommunicator shall make every effort to determine the appropriate responding agency and complete the disposition of the call.
- d) *The agreements shall provide that, once an emergency unit is dispatched in response to a request through the system, such unit shall render its services to the requesting party without regard to whether the unit is operating outside its normal jurisdictional boundaries. [50 ILCS 750/14]*

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**Section 725.510 Electronic Communication Devices**

Except for the purpose specifically indicated and authorized by law, the installation of or connection to the 9-1-1 system network of an automatic alarm, automatic alerting device, or mechanical dialer that causes the number 9-1-1 to be dialed is prohibited in a 9-1-1 system (e.g., elevator one button phones, security pole one button phones, or burglar alarms).

**Section 725.515 Physical Security**

- a) The 9-1-1 authority must ensure that critical areas of a PSAP, backup PSAP and secondary PSAP shall have adequate physical security to prevent malicious disruption of service and shall be protected against damage due to vandalism, terrorism and civil disturbances. These critical areas shall, at a minimum, include all communications equipment, PSAP personnel, electronic equipment rooms, and mechanical equipment rooms that are vital to the operation of the PSAP.
- b) The PSAP and PSAP personnel shall be isolated from direct public contact.
- c) Entry to the PSAP shall be restricted to authorized persons only. Additionally, doors that lead directly from the exterior into the PSAP or from within a building into the PSAP shall be secured at all times.
- d) Access to the communications and electronic equipment rooms shall be restricted within the building by means of secured doors.
- e) Wherever practical, service entrances for electric and telephone service shall be underground, at least to the respective utilities' nearest serving distribution point. Protective measures shall be taken against vandalism and natural or manmade hazards at each PSAP.
- f) The PSAP shall be equipped with a fire extinguisher. Personnel shall be instructed in proper use of these extinguishers.

**Section 725.520 9-1-1 Traditional Legacy Service Database**

- a) 9-1-1 database queries will only be allowed by PSAPs for purposes of dispatching or responding to an emergency call or for database integrity verification as set forth in subsection (c).

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- b) Prior to an initial database integrity verification, the 9-1-1 authority shall obtain a court order detailing the information that is to be disclosed and the reason for disclosure.
- c) The 9-1-1 database shall have the capability of allowing database verification queries, provided that the following procedures are adhered to:
  - 1) The 9-1-1 authority shall be responsible for providing a level of security and confidentiality to the database that will prohibit random inquiries;
  - 2) Direct access to 9-1-1 database information will be under strict control and, when technically feasible, a password will be assigned for access by authorized persons only;
  - 3) Database verification queries shall be by subscriber number only and as necessary for purposes of database integrity. Queries in excess of 10 per 24-hour period will only be done with 2 or more days advance notice to the respective 9-1-1 system provider for scheduling purposes. Queries may be for the specific purpose of cross-checking information in the 9-1-1 database with other sources of information, including telephone and other directories, maps, municipal database listings, etc., and for verifying that database update information provided to the 9-1-1 system provider has indeed been posted and is correct. On-site 9-1-1 databases are exempt from 9-1-1 system provider advance notification requirements of this Section;
  - 4) Information retrieved will be used exclusively for the maintenance, update and verification of the 9-1-1 database except as otherwise specified in subsection (a). Any other use is expressly prohibited. The information is subject to strict non-disclosure agreements between the various OSPs, 9-1-1 system providers and 9-1-1 authority. All personnel associated in any way with the 9-1-1 authority and the 9-1-1 systems are bound by these agreements.
  - 5) Trunks/facilities that are not used to transport 9-1-1 emergency calls into the PSAP are prohibited from being connected to the 9-1-1 CPE in any way to allow for queries of the 9-1-1 database.

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- 6) Database queries for the purpose of database verification shall be limited to off-peak times.
- 7) Database queries shall not be made if there is any known outage or impairment in the database system, including a database data link outage. In the event of an outage, the 9-1-1 system provider shall treat outage notification of the 9-1-1 authority regarding database query suspension as a priority. When practicable, this notification shall be made not later than 15 minutes after a confirmed incident that will cause database queries to be suspended.
- d) Each telecommunication carrier shall provide updates to the appropriate 9-1-1 system provider for the 9-1-1 database on a daily basis or more frequently when technology supports it, Monday through Friday during business hours.
- e) A 9-1-1 authority using an on-site database is restricted from making any changes to the 9-1-1 data that has been downloaded for its use. Only the 9-1-1 system provider has the authority to correct errors or provide updates to the database. The 9-1-1 authority must adhere to the proper error resolution procedures as specified in subsection (g)(1).
- f) 9-1-1 authorities, 9-1-1 system providers and telecommunications carriers shall utilize mutually acceptable and agreed upon standards as prescribed, at a minimum, by the NENA Standards for 9-1-1 databases.
  - 1) Data Formats for ALI, MSAG and GIS (02-010, v9);
  - 2) 9-1-1 Data Management (02-011, v7); and
  - 3) Provisioning and Maintenance of MSAG Files to VDBs and EKDBS (02-013, v3).
- g) It shall be the joint responsibility of the 9-1-1 authority, the 9-1-1 system provider and telecommunications carriers to ensure that the error ratio of each 9-1-1 system's database shall not, at any time, exceed 1%.
- h) The 9-1-1 authority shall forward all error reports within two business days after finding the error to its 9-1-1 system provider.

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- i) If the error is a record of the 9-1-1 system provider, it must be corrected and updated within two business days after receipt of the error. If the error is for a participating telecommunications carrier, the 9-1-1 system provider shall forward the error to the appropriate telecommunications carrier for resolution.
- j) Any telecommunications carrier receiving an error record from the 9-1-1 system provider has two business days upon receipt of the error to process the corrections and forward the appropriate updates to the 9-1-1 system provider. If the error is for an OSP, the 9-1-1 authority will forward those on to the appropriate company for review.
- k) The 9-1-1 authority shall retest and/or validate that all errors have been corrected (e.g., no record found, misroutes).
- l) The 9-1-1 authority shall, on a continuing basis, maintain the MSAG (or GIS database or functional equivalent), the ELT for each ESN and the associated telephone numbers for the ELTs.
- m) Upon a written request of the 9-1-1 authority, the 9-1-1 system provider shall submit, within 14 working days, a report to assist in the validation of the accuracy of the 9-1-1 database. Before this report is delivered to the 9-1-1 authority, the 9-1-1 authority shall obtain a court order allowing the 9-1-1 system provider to release the information. A single court order may be used to comply with this subsection and subsection (e).
  - 1) This report shall include the following information when available in the 9-1-1 database:
    - A) telephone number – area code, prefix and number in separate fields;
    - B) pilot number – single telephone number used to tie multiple numbers within a system together;
    - C) service (civic) address – including street name, house number or equivalent, suffix, directional, community name, state, zip code and location and/or descriptive information, including intersection if MSAG indicates an intersection, in separate fields;

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- D) billing address – if different than the service address, in separate fields, to be provided on a telephone number only basis pursuant to procedures defined by the telecommunications carrier and the 9-1-1 authority. Billing address information shall be subject to non-disclosure agreements;
  - E) name – first, last and middle names or initials, in separate fields;
  - F) date service was initiated – the month, day and year that service was initiated, in separate fields. If this information is not available, the date reflecting the most current service order activity may be provided instead;
  - G) type of service – residential, business, coin, etc.;
  - H) PBX/Centrex Extensions/Station Numbers – identify those numbers that are part of a PBX/Centrex system when this information is available;
  - I) surcharge status – when this information is available, the report shall identify those lines on which a surcharge is being collected and the date on which the collection was initiated. Identify those lines on which no surcharge is being collected and the reason for each exemption, including telecommunications carrier lines, in separate fields;
  - J) Emergency Service Number (ESN) – appropriate ESN, if assigned, is to be made available only from the primary telecommunications carrier providing database development and routing services.
- 2) This report may be requested by the 9-1-1 authority in writing, at a maximum, on a monthly basis. The information in this report is considered proprietary and shall be used exclusively for validating the accuracy of the 9-1-1 database. This report will be delivered in an electronic format. It will not be delivered in paper format. There will be a charge for this report that will be a tariffed item by each 9-1-1 system provider.
- n) A 9-1-1 authority that has or is in the process of transitioning to an NG9-1-1 system when the 9-1-1 traditional legacy service database will be used in

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conjunction with, or eventually be replaced with, dynamic data must provide a detailed explanation of the initial development and ongoing maintenance of necessary databases and in the NG9-1-1 final plan or modification, pursuant to Section 725.205(f).

**Section 725.525 Call Boxes**

- a) Except as otherwise provided in this Part, call boxes shall be a part of a 9-1-1 system that offers 9-1-1 traditional legacy service. Call boxes shall be provisioned to adequately serve a system in the event the central office is isolated from the 9-1-1 system provider's selective router or its functional equivalent. Call boxes shall only be provisioned to central offices and to those remote central offices that have the capability to stand alone and function when severed from the host central office. A high priority of attention shall be given to all trouble reports and requested restorations. Call boxes shall be designed to meet the following requirements:
- 1) Call boxes shall have a minimum of two lines, with additional lines as agreed to by the 9-1-1 authority and the telecommunications carriers;
  - 2) The type of vault used to house the call box circuitry shall be weather resistant and have a locking capability;
  - 3) When technically feasible, the call boxes shall be provisioned with a transfer switch for use by authorized personnel to route emergency calls from the network to the call box jacks;
  - 4) The call boxes shall be provisioned with the lines busied out until the transfer switch is thrown to prevent calls from ringing into an unattended call box;
  - 5) The call boxes shall be equipped with an intrusion alarm at an additional cost to be assessed to the 9-1-1 authority through a tariff filed pursuant to Section 9-201 of the Public Utilities Act;
  - 6) Call boxes shall be located, installed and maintained so that 9-1-1 system personnel have unrestricted access to the call box 24 hours per day, 7 days per week. If the call box is to be located within any secured area, the

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telecommunications carrier shall provide the 9-1-1 authority immediate, unrestricted access to the secured area; and

- 7) Calls boxes shall be tested by the 9-1-1 authority in conjunction with the telecommunications carrier annually, at a minimum.
- b) All telecommunications carriers shall coordinate call box procedures or alternative call box procedures with the 9-1-1 authority. When call boxes are not a viable solution for a telecommunications carrier, the following options are available:
- 1) Diverse routing is required of telecommunications carriers if used in lieu of a call box and shall be provisioned to meet the P.01 grade of service by the telecommunications carrier and shall meet the following requirements:
    - A) A minimum of two facility paths that are in physically separate cable routes between the central office and the 9-1-1 selective router or functional equivalent; and
    - B) Trunks divided as equally as possible in the two facility paths between the central office and the 9-1-1 selective router or functional equivalent. Trunking shall be provisioned as stated in subsection (c).
  - 2) Other viable solutions as technology permits may be utilized with prior approval of the Commission.
- c) The 9-1-1 authority shall develop call box procedures to ensure the following:
- 1) When call box operation is necessary, appropriately trained personnel shall respond to the call boxes in accordance with the 9-1-1 authorities' call box procedures;
  - 2) That procedures are developed between 9-1-1 authorities involved in a split exchange situation to determine who will respond to the call box in the instance of outages or disaster;

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- 3) Once the 9-1-1 authority has been notified of an outage occurring in the 9-1-1 system, it must make notification to any other PSAPs in the 9-1-1 system that are affected by the outage.
- 4) The 9-1-1 authority may also meet the call box requirement by provisioning call forwarding to a local answering point in the same local exchange or rate center as the central office. The call box transfer switch must be manually activated at the central office and then calls can be forwarded to a predetermined location where the emergency calls can be taken and handled appropriately.

## SUBPART F: SURCHARGE

**Section 725.600 Surcharge Administration and Monthly Report to the Emergency Telephone System Board**

- a) Telecommunications carriers, whether they are considered resellers or facility based carriers, are responsible for their own surcharge administration. Each is responsible for collecting the 9-1-1 surcharge from its subscribers for the appropriate jurisdiction and shall remit it to the proper 9-1-1 authority pursuant to the ETSA.
- b) Additionally, a VoIP provider service in Illinois that is required to register with the Illinois Commerce Commission, pursuant to Section 13-401.1 of the Public Utilities Act shall charge and collect from its end-user customers, and remit to the appropriate local authority, 9-1-1 surcharges in the same manner as are charged and collected upon end-user customers of local exchange telecommunications services and remitted by the local exchange telecommunications carriers for local enhanced 9-1-1 service.
- c) In addition, each entity collecting and remitting surcharges shall provide to the 9-1-1 authority a detailed monthly listing of the actual number of network connections, including the number of residential, business, payphone, Centrex, PBX and exempt lines, and the number of residential and business subscriptions. See Appendix A.

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**Section 725.APPENDIX A Monthly Surcharge Report to the 9-1-1 Authority**

Company Name: \_\_\_\_\_

Remittance for (Month/Year): \_\_\_\_\_

Total Number of Access Lines: \_\_\_\_\_

	Number	Rate	Revenues
Residential Lines	_____	_____	_____
Residential VoIP Subscriptions	_____	_____	_____
Business Lines	_____	_____	_____
Business VoIP Subscriptions	_____	_____	_____
Pay Phone Lines	_____	_____	_____
Centrex Lines	_____	_____	_____
PBX Lines	(____)		
Exempt Lines	(_____)		
<b>TOTALS</b>	_____		_____

\_\_\_\_\_  
Date Prepared

\_\_\_\_\_  
Preparer

\_\_\_\_\_  
Telephone Number

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: General Provisions
- 2) Code Citation: 89 Ill. Adm. Code 101
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
101.10	Amendment
101.20	Amendment
101.30	Amendment
101.40	Amendment
101.50	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: February 1, 2013; 37 Ill. Reg. 903
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: The following changes have been made:

In Section 101.10(a), after "the" add "Department of Healthcare and Family Services, the Department of Human Services and".

In Section 101.10(b) delete the entire subsection.

In Section 101.10(c), strike "c" and add "b".

In Section 101.10(d), strike "d" and add "c", strike "Rules" and add "rules" and strike "Regulations" and add "regulations".

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In Section 101.10(e), strike "e" and add "d".

In Section 101.20 before the Section on definitions added, "The definitions in this Section apply to terms used by the Department of Healthcare and Family Services, the Department of Human Services and local governmental units in administering programs under the Public Aid Code. These definitions apply to the rules of those entities unless a specific, alternative definition is created in those rules.".

In Section 101.20 deleted the definition, "Family and Children Assistance Case" .

In Section 101.50(a)(2)(B), strike "the Medicaid and Welfare Fraud Hotline" and add "HFS/DHS".

- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? Yes, July 13, 2012; 36 Ill. Reg. 10176.
- 14) Are there any other rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: Part 101 is being amended to comply with the SMART Act, PA 97-0689.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

The full text of the Adopted Amendments begins on the next page:

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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## TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF ~~HEALTHCARE AND FAMILY SERVICES~~PUBLIC AID  
SUBCHAPTER a: GENERAL PROVISIONS

## PART 101

## GENERAL ADMINISTRATIVE PROVISIONS

## Section

101.1	Incorporation by Reference
101.10	Applicability
101.20	Definitions
101.30	Assistance Programs
101.40	Assistance Program Restrictions
101.50	Reporting Suspected Fraud or Abuse

AUTHORITY: Implementing Articles I, II and VIIIA, and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. I, II and VIIIA, and 12-13].

SOURCE: Filed and effective December 30, 1977; emergency amendment at 2 Ill. Reg. 5, p. 194, effective January 23, 1978, for a maximum of 150 days; emergency amendment at 2 Ill. Reg. 19, p. 108, effective May 1, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 25, p. 50, effective June 24, 1978; amended at 2 Ill. Reg. 33, p. 27, effective August 17, 1978; amended at 3 Ill. Reg. 43, p. 196, effective October 15, 1979; emergency amendment at 4 Ill. Reg. 1, p. 78, effective January 1, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 23, p. 80, effective May 23, 1980; amended at 5 Ill. Reg. 1369, effective January 29, 1981; peremptory amendments at 5 Ill. Reg. 10072, 10076, and 10079, effective October 1, 1981; amended at 5 Ill. Reg. 12728, effective November 1, 1981; codified at 7 Ill. Reg. 5195; amended at 13 Ill. Reg. 3897, effective March 17, 1989; emergency amendment at 19 Ill. Reg. 10220, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15676, effective November 3, 1995; emergency amendment at 21 Ill. Reg. 8638, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13619, effective October 1, 1997; amended at 22 Ill. Reg. 6991, effective April 1, 1998; amended at 26 Ill. Reg. 2039, effective February 1, 2002; emergency amendment at 36 Ill. Reg. 10176, effective July 1, 2012 through June 30, 2013; amended at 37 Ill. Reg. 10152, effective June 27, 2013.

**Section 101.10 Applicability**

- a) ~~This Part applies~~These Rules apply to activities of the Department of Healthcare and Family Services, the Department of Human Services and Illinois Department

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~~of Public Aid and~~ local governmental units in administering those programs and activities authorized by ~~Sections 1-1 et seq. of~~ the Illinois Public Aid Code [305 ILCS 5](Ill. Rev. Stat. 1981, ch. 23, pars. 1-1 et seq.) and any other applicable statutes.

- b) ~~This codification of Rules incorporates into one set the Rules of the Department, and replaces the Administrative and Categorical Rules and Regulations and the General Assistance and Local Aid to the Medically Indigent Rules and Regulations previously on file with the Secretary of State. These Rules in no way affect the Rules for Medical Vendor Administrative Proceedings filed and effective on an emergency basis December 27, 1977.~~
- b)e) Should any ~~Rule, subdivision, clause, phrase, or~~ provision of ~~this Part~~ these Rules be unconstitutional or invalid for any reason whatsoever, ~~thesesuch~~ holdings shall not affect the validity of the remaining portions of ~~this Part~~ these Rules.
- c)d) All ~~rules~~ Rules and ~~regulations~~ Regulations of the Illinois Department of Public Aid previously filed with the Secretary of State, with the exception of the Rules for Medical Vendor Administrative Proceedings filed and effective on an emergency basis December 27, 1977, ~~wereare hereby~~ replaced by ~~adoption of this Part~~ this codification.
- d)e) ~~This Part~~ These Rules shall be operative only to the extent that ~~it does~~ they do not conflict with any Federal law or regulation governing Federal grants to this State for public assistance programs.

(Source: Amended at 37 Ill. Reg. 10152, effective June 27, 2013)

**Section 101.20 Definitions**

The definitions in this Section apply to terms used by the Department of Healthcare and Family Services, the Department of Human Services and local governmental units in administering programs under the Public Aid Code. These definitions apply to the rules of those entities unless a specific, alternative definition is created in those rules.

"AABD-" ~~or~~ "Aid to the Aged, Blind or Disabled" – ~~Financial~~ financial assistance and medical assistance available to individuals who have been determined to be aged, blind or disabled as defined by the Social Security Administration.

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"Adequate Consideration:" — The receipt of goods, monies or services at least in the amount of the fair market value of the property sold.

"Adult Cases:" — A case in which no child is included in the assistance unit.

"Adverse Action:" — Any action ~~that~~which reduces ~~SNAP~~SNAP food stamp benefits or terminates participation in ~~SNAP~~SNAP the food stamp program within a certification period.

"AFDC:" or "Aid to Families with Dependent Children" — ~~Financial~~financial assistance and medical assistance available to families with one or more dependent children or in behalf of dependent children placed in foster care by the Department of Children and Family Services (DCFS).

"AFDC-F:" — Medical ~~assistance~~Assistance for an eligible child under DCFS guardianship.

"Agency Error:" — An action or inaction of ~~DHS or HFS~~the Department resulting in assistance benefits being furnished to or in behalf of a client for which the client is not eligible.

"Applicant:" — An individual requesting assistance by completion of a signed, written application form or a person in whose behalf a signed written application form is completed requesting assistance.

"Application:" — A request for assistance by means of a completed, signed designated form. For ~~SNAP~~SNAP food stamp purposes, only a name, address and signature are needed on the form.

"Assistance Unit:" — The individual or individuals living together for whom ~~DHS or HFS~~the Department determines eligibility and, if eligible, provides financial and/or medical assistance as one unit.

"Benefit Allotment" — The total dollar value of the SNAP benefits that a household is authorized to receive.

"Caretaker Relative:" — A relative, as specified in this definition below, with whom a child must live to be eligible for TANF and who is providing care, supervision and a home for the child.

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Blood or adoptive relatives within the fifth degree of kinship:

Father – Mother

Brother – Sister

Grandmother – Grandfather (including up to great-great-great)

Uncle – Aunt (including up to great-great)

Nephew – Niece (including up to great-great)

First Cousin

First Cousin once removed (child of first cousin)

Second Cousin (child of great-aunt/uncle)

Step-Relatives:

Step-Father – Step-Mother

Step-Brother – Step-Sister

Person who is or has been married to one of the listed blood, adopted or step-relatives.~~one of the above relatives~~

"Categorical Assistance Programs:" – TANF, AABD and related MANG programs.

"Categorically Eligible:" – The meeting of all eligibility requirements for a categorical assistance program other than financial needs.

"Certification for SNAP Benefits~~Food Stamps~~:" – Authorization of eligibility of a household for SNAP~~the food stamp program~~.

"Certification Period:" – The period of time for which a household is authorized to participate in SNAP~~the food stamp program~~.

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"Certifying Office:" – The ~~DHS~~DPA local office ~~or General Assistance unit office~~ responsible for certification of SNAP~~food stamp program~~ participants.

"Client:" – The adult in the family or unit applying for assistance or receiving assistance on behalf of the family.

"Client Error:" – A client's mistake, misunderstanding, misrepresentation or concealment of information or failure to report information promptly ~~that~~which results in financial and/or medical assistance being paid to or in behalf of a recipient for which the recipient is not eligible.

"Correspondent:" – A specific individual who has been legally designated to handle the affairs of another individual, that is, parents, court appointed guardian or conservator.

~~"Coupon Allotment." – The total dollar value of the food stamp coupons that a household is authorized to receive.~~

"DCFS:" – Illinois Department of Children and Family Services.

"Department:" or "HFS" – ~~The~~ Illinois Department of Public Aid~~Healthcare and Family Services~~.

"Dependent Child:" – A child age 18 or under who is living with a relative. If age 18, the child must be a full-time high school (or equivalent) student.

"DHS:" – Illinois Department of Human Services.

"DHS-MH/DD" – The Divisions of Mental Health and Developmental Disabilities of the Department of Human Services.

"DHS-DRS" – The Division of Rehabilitation Services of the Department of Human Services.

"Disbursing Order:" – An invoice voucher form given to a client authorizing a vendor to provide specified goods and/or services.

"Disposition of an Application:" – The determination of eligibility or ineligibility.

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"Diverted Income:" — Earned or unearned income of a parent used to meet the needs of ineligible ~~person or~~ persons, including the parent, his or her~~their~~ dependent ~~child or~~ children or his or her~~their~~ spouse.

~~"DMHDD." Formerly Illinois Department of Mental Health and Developmental Disabilities. Now part of DHS.~~

"DOC:" — Illinois Department of Corrections.

"DOL:" — Illinois Department of Labor.

~~"DORS." Formerly Illinois Department of Rehabilitation Services. Now part of DHS.~~

"Earmarked Income:" — Income restricted for the use of an individual by court order or by legal stipulation of a contributor. Only income of a child may be considered earmarked for HFS or DHS~~Departmental~~ purposes. The income of an eligible child who has siblings in the home receiving TANF financial assistance cannot be earmarked.

"Earned Income:" — Remuneration derived through the receipt of wages or salary for services performed as an employee or profits from activity in which the individual is self-employed.

"Effective Date:" — The date for which case action is authorized.

"Enrolled MANG Participant:" — Person or unit meeting the nonfinancial factors of eligibility.

"Established Twelve-Month Period:" — The period of 12 calendar months over which income is compared to the applicable MANG standard.

"Expedited Issuance:" — Authorization of SNAP~~food stamp~~ benefits after the household has been determined to be destitute or to have zero net income.

"Expedited Service:" — An immediate processing of a SNAP~~food stamp~~ application and determination of eligibility for expedited issuance.

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~~"Family and Children Assistance Case." A General Assistance case in which case eligibility is based on the presence of an eligible child.~~

~~"FNS/FCS." – The Food and Nutrition Consumer Service of the United States Department of Agriculture.~~

"Final Administrative Decision." – A decision made by HFS or DHS~~the Department~~ as a result of an appeal. It either upholds or reverses the appealed action or determines a lack of jurisdiction.

"Financial Assistance." – Public ~~assistance~~Assistance paid in the form of a cash benefit to a recipient for income maintenance needs. Medical assistance and SNAP~~food-stamp~~ benefits are not considered financial assistance.

"Financial Factors of Eligibility." – Income, assets and Department levels of assistance.

"Financially Eligible." – The meeting of all financial factors of eligibility.

"Fiscal Month." – Begins on a given day in one calendar month and ends on the day prior to the same given day in the next calendar month.

~~"Food Coupons." Same as food stamps.~~

~~"Food Stamp Benefits." The cash value of benefits which a food stamp unit receives from the program.~~

~~"Food Stamp Employment and Training." Employment and training program for food stamp recipients.~~

~~"Food Stamp Household or Unit." For purposes of the food stamp program, a household or unit is defined as any of the following:~~

"Full-Time Employment." – Employment of 30 hours per week or more.

"GA." or "General Assistance" – Financial~~financial~~ and medical assistance provided by a local governmental unit~~available~~ to eligible needy families or individuals who are ineligible to receive assistance through a categorical assistance program.

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~~"GA Community Work and Training Program." – A program, applicable to GA outside the City of Chicago only, designed to increase employability of General Assistance recipients through constructive work experience, adult education, vocational training and gainful employment.~~

"Grant:" – The total amount of a monthly financial assistance payment.

"Grant Cases:" – Public assistance cases authorized for financial assistance payments to the recipient.

"Head of Household:" – The person in whose name application is made for participation in SNAP~~the food stamp program~~. This person is normally the individual who is the household's primary source of income.

"Health Maintenance Organization" or ("HMO):" – Licensed by the Illinois Department of Insurance as a non-profit incorporated agency whose purpose is to provide preventive health care and medical services.

"Healthy Kids:" – Early and periodic screening, diagnosis and treatment services provided to children from birth through 20 years of age.

"Hearing:" – The actual presentation and consideration of the issue under appeal before a hearing officer of the Department.

"HFS" – Illinois Department of Healthcare and Family Services.

"HIB:" – Hospital Insurance Benefits provided by Title XVIII of the Social Security Act (Medicare) (42 USCU.S.C., 1395 et seq.).

"Initial Prorated Entitlement" or ("IPE):" – Financial ~~assistance~~Assistance to cover the period from the initial point of eligibility (application for assistance or initial needs of a person being added to the assistance unit) through two days after the mailing date of the first regular monthly assistance warrant.

"In-Kind Income:" – Income received by or paid in behalf of an individual in a form other than money.

"Intermediate Care Facility" or ("ICF):" – Provides basic nursing care and other

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restorative services under periodic medical direction. Many of these services may require skill in administration. ~~The~~ Such facilities are for residents who have long term illnesses or disabilities ~~that~~ which may have reached a relatively stable plateau.

"Intermediate Care Facility for the ~~Developmentally Disabled~~ ~~Mentally Retarded~~" or ("~~ICF/DDMR~~)." – Provides primarily for ambulatory adults with developmental disabilities and addresses itself to the needs of ~~intellectually disabled persons~~ ~~mentally-retarded~~ and/or ~~those~~ with related conditions. ~~These~~ Such facilities are for residents who have physical, intellectual, social and emotional needs.

~~"JTPA." – Job Training Partnership Act.~~

"Local Governmental Unit." – Every county, city, village, incorporated town or township charged with the duty of providing public aid under General Assistance and County Veterans Assistance Commissions providing assistance to indigent war veterans and their families.

"Local Office." – ~~DHS~~ ~~Department of Public Aid~~ offices ~~that~~ which serve clients living within a designated geographical area.

"Lump-Sum Payment." – An extraordinary or non-recurring income payment received by a client.

"MAG." or "~~Medical Assistance Grant-eases~~" – ~~Medical~~ ~~medical~~ assistance paid on behalf of a recipient of financial assistance.

"MANG." – ~~Medical Assistance No Grant-eases~~ – ~~Medical~~ ~~medical~~ assistance paid on behalf of a recipient of categorical assistance who is not receiving financial assistance.

"MANG(AABD)." – Medical assistance available to individuals who have sufficient income and assets to meet all maintenance needs other than medical care and who are receiving Supplemental Security Income benefits or who are determined to be aged, blind or disabled by ~~DHS or HFS~~ ~~the Department of Public Aid~~.

"MANG(C)." or "~~Medical Assistance to Needy Families with Children~~" –

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~~Available~~ ~~available~~ to families with one or more children who would qualify for TANF on the basis of non-financial eligibility factors but have sufficient income and assets to meet all maintenance needs other than medical care.

"Medicaid:" ~~is~~ ~~Medical assistance issued by HFS~~ ~~the Department~~ under provisions of Title XIX of the Social Security Act (42 ~~USC~~ ~~U.S.C.~~ 1396); MAG and MANG.

"Medical Assistance:" ~~is~~ ~~Medicaid~~.

"Medical Card:" ~~is~~ ~~A means of identification used to verify an individual's eligibility for medical assistance~~.

"Medicare:" ~~is~~ ~~Payment for medical care under the provisions of Title XVIII of the Social Security Act~~ ~~(42 USC 1395)~~.

"Migrant Worker:" ~~is~~ ~~Any person residing temporarily in and employed in Illinois who moves seasonally from one place to another for the purpose of employment in agricultural activities, including the planting, raising or harvesting of any agricultural or horticultural commodities and the handling, packing or processing of those~~ ~~such~~ commodities on the farm where produced or at the point of first processing.

"OASDI:" ~~or~~ ~~"Old Age, Survivors, and Disability Insurance"~~ ~~–~~ ~~Often~~ ~~often~~ termed "Social Security".

"OJT:" ~~or~~ ~~"On the Job Training~~ ~~programs"~~ ~~–~~ ~~Programs~~ sponsored through the TANF ~~or~~ ~~AFDC~~ JOBS Program, ~~SNAP~~ ~~Food Stamp~~ Employment and Training Program or ~~WIA~~ ~~JTPA~~.

"Participant:" ~~is~~ ~~A person taking part in~~ ~~SNAP~~ ~~the food stamp program~~ or a ~~DHS~~ ~~Departmental~~ employment and training program.

"Prepaid Health Plan:" ~~is~~ ~~An organized system of health care responsible for providing or assuring the delivery of comprehensive health maintenance and treatment services to a voluntarily enrolled population~~.

"Recipient:" ~~is~~ ~~An individual who receives benefits under an assistance program~~.

"Skilled Nursing Facility" ~~or~~ ~~("SNF")~~ ~~–~~ ~~A group care facility licensed by the~~

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Illinois Department of Public Health ~~that~~which provides skilled nursing care, continuous skilled nursing observations, restorative nursing and other services under professional direction with frequent medical supervision. ~~The~~Such facilities are provided for patients who need the type of care and treatment required during the post-acute phase of illness or during reoccurrences of symptoms in long-term illness.

"Skilled Nursing Facility for Pediatrics" ~~or ("SNF/PED)";~~ – A group care facility licensed by the Illinois Department of Public Health ~~that~~which provides nursing care and habilitative and/or rehabilitative care to children under ~~18~~eighteen years of age. ~~The~~Such facilities are for residents primarily diagnosed ~~with an intellectual disability~~mentally-retarded or having related conditions.

"SMIB:" ~~or "Supplementary Medical Insurance Benefits";~~ – ~~Coverage~~coverage provided under Title XVIII of the Social Security Act for medical services other than hospitalization.

"SNAP Benefits" – The cash value of benefits a SNAP unit receives from the program.

"SNAP Employment and Training" – Employment and training program for SNAP recipients.

"SNAP Household or Unit" – For purposes of SNAP, a household or unit is defined as any of the following:

An individual living alone;

An individual living with others but customarily purchasing food and preparing meals for home consumption separate and apart from others;

A group of individuals who live together and customarily purchase food and prepare meals together for home consumption or who, because of their relationship, are required to qualify for SNAP benefits as a unit.

"Specified Relative:" ~~–~~ – Same as caretaker relative.

"Spendedown:" ~~–~~ – The amount by which a client's nonexempt income during the eligibility period exceeds the MANG income and asset standards.

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"SSA:" ~~— The Social Security Administration of the Department of Health and Human Services.~~

"SSI:" or "Supplemental Security Income" — ~~A~~ program administered by the Social Security Administration providing monthly aid to aged, blind or disabled~~Aged, Blind and Disabled~~ individuals.

"Student:" ~~—~~ An individual who is enrolled at least half time (as defined by the institution) in any elementary grade school, high school, vocational school, technical school, training program or institution of higher education. Enrollment in a mail, self-study or correspondence course does not meet the definition of a student.

"Supervision:" ~~—~~ Exercising of responsibility for the child's welfare by the caretaker.

"TANF:" or "Temporary Assistance for Needy Families" ~~—~~ Financial and medical assistance available to families with one or more dependent children.

"Temporary Caretaker:" ~~—~~ Another individual temporarily acting as a caretaker (not included in the assistance unit) when no specified relative is available.

"UI:" ~~—~~ Unemployment Insurance ~~Benefits~~.

"Unearned Income:" ~~—~~ All income other than earned income.

"Utilization Control:" ~~—~~ Evaluation and review ~~by the Department~~ of a recipient's need for care ~~facility~~, and certification of a patient's need for care as established by HFS physicians, DHS staff and the Department of Public Health or other designated agencies or authorities.

"Vendor Payment:" ~~—~~ Direct payment to vendors for items or services provided to clients.

"WIA" — The Federal Workforce Investment Act of 1998 (29 USC 2801 et seq.).

"Work and Basic Skills Training Program:" ~~— The DHS~~ The Department's employment and training program for TANF recipients.

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"Work Experience." – ~~The DHS Department~~ program ~~that~~which provides experience in a job.

(Source: Amended at 37 Ill. Reg. 10152, effective June 27, 2013)

**Section 101.30 Assistance Programs**

- a) The types of assistance programs administered by ~~DHS~~the Illinois Department of Public Aid include: financial assistance, ~~medical assistance~~ and ~~SNAP benefits~~food stamps. ~~The types of assistance programs administered by HFS include: medical assistance and child support services.~~
- b) Financial Assistance Programs – ~~consist~~consists primarily of direct cash payments to recipients. The various financial assistance programs are:
- 1) Aid to the Aged, Blind or Disabled – State Supplemental Payment  
For aged, blind or disabled persons.
  - 2) Temporary Assistance for Needy Families  
For families with one or more children.
  - 3) Refugee Resettlement Program (RRP)  
For refugees from any country.
  - 4) Repatriate Program  
For United States citizens and their dependents returned from a foreign country by the U.S. Department of State.
  - 5) ~~General Assistance~~  
~~For individuals and families who do not qualify for assistance under the Aid to the Aged, Blind or Disabled (AABD) – State Supplemental Payment (SSP), Temporary Assistance for Needy Families (TANF) or federal Supplement Security Income (SSI) programs and who meet GA program requirements.~~
- c) Medical Assistance – under which payments are made to medical providers for services provided to recipients.

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- 1) **Medicaid**  
For persons eligible for financial assistance under the AABD-SSP and TANF programs and for individuals not eligible for financial assistance but who meet the requirements of 89 Ill. Adm. Code 120~~those programs~~ for medical assistance ~~only~~. This includes pregnant women of any age with no other children who would be eligible for TANF or MANG (CR) if the child had already been born. Medicaid is provided under the AFDC-F program for children under DCFS guardianship who have been placed in licensed foster care or in the home of a relative.
- 2) **Healthy Kids**  
A preventative health program for all clients who are under 21 years of age and who are receiving AFDC, AABD, RRA, ~~GA~~, MANG or TANF. Through Healthy Kids, persons are given periodic screening examinations at certain ages from birth through age 20. The screening is to diagnose and treat health problems at an early stage.
- 3) ~~General Assistance Medical~~  
~~For persons receiving financial benefits under the GA program.~~
- d) ~~SNAP Food Stamps~~ – provides increased food purchasing benefits to recipients. ~~SNAP Food Stamp~~ benefits are available to individuals who meet the eligibility requirements of the Food and Nutrition Service of the U.S. Department of Agriculture in accordance with the Food ~~and Nutrition Stamp~~ Act of ~~2008~~1977 (7 ~~USC 2013~~U.S.C. 2017 et seq.).
- e) Title IV-D – attempts to collect child support payments from absent parents ~~on~~ behalf of children receiving assistance. ~~HFS~~The Department enlists the cooperation of the caretaker relative in identifying, locating and securing support from an absent parent or parents or putative father. ~~The~~Such support received is subsequently paid directly to ~~HFS~~the Department.

(Source: Amended at 37 Ill. Reg. 10152, effective June 27, 2013)

**Section 101.40 Assistance Program Restrictions**

- a) An individual shall be eligible to receive financial assistance under only one of the following types of assistance programs at any one time:

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- 1) Categorical Assistance (TANF or AABD); ~~or;~~
  - ~~2) General Assistance, or~~
  - ~~23) Assistance to Refugees, Entrants and Repatriates.~~
- b) An individual shall be eligible to receive financial and medical assistance in only one case under one assistance program, at any one time, except ~~that an-~~ ~~1) An~~ individual who currently receives Categorical Assistance from another ~~state~~ ~~State~~ and has established Illinois residence (in accordance with 89 Ill. Adm. Code 112.20, 113.20, ~~114.20, 120.211,~~ 120.311, or 121.21) may receive Supplemental Categorical Assistance in Illinois when the amount of the Illinois assistance payment level to which the individual is entitled exceeds the amount received from the other ~~state~~ ~~State~~, if the excess is at least \$10.~~00~~.
- ~~2) An individual who is currently receiving General Assistance shall be eligible to receive GA during the pendency of an application for Categorical Assistance or to receive the difference between the amount of the GA grant and the amount of the Categorical Grant for the month in which the individual is determined eligible for Categorical Assistance.~~
- c) An individual shall not be eligible to receive ~~SNAP benefits~~ ~~food stamps~~ as a member of more than one household at any one time.

(Source: Amended at 37 Ill. Reg. 10152, effective June 27, 2013)

**Section 101.50 Reporting Suspected Fraud or Abuse**

- a) Any suspected fraud or abuse related to the Medical Assistance, ~~Children's Health Insurance, Covering All Kids Health Insurance~~ ~~KidCare~~, Child Support Enforcement, ~~Transitional Assistance~~, Aid to the Aged, Blind and Disabled, Temporary Assistance to Needy Families, ~~SNAP~~ ~~Food Stamp~~ and Child Care Programs, and all other programs administered ~~by the Department or~~ by the Department of Human Services ~~or the Department of Healthcare and Family Services as successor agency to the Department~~, should be reported:
- 1) in person or by U.S. Mail to the Office of Inspector General, Department of ~~Healthcare and Family Services~~ ~~Public Aid~~, 404 North Fifth Street, Springfield, Illinois 62702;

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## 2) or by:

- A) telephone to the Office of Inspector General at [217/524-6037217/524-7658](tel:21752460372175247658); or
- B) toll free telephone to ~~HFS/DHS~~[the Medicaid and Welfare Fraud Hotline](tel:8002528903) at 800/252-8903; or
- C) e-mail at [hfs.oigwebmaster@illinois.gov](mailto:hfs.oigwebmaster@illinois.gov); or ~~oigwebmaster@mail-idpa.state.il.us~~.
- D) online at <http://www.state.il.us/agency/oig/reportfraud.asp>.

## b) Referrals

- 1) Referrals of suspected fraud or abuse on the part of providers, contractors, State or other governmental employees, recipients of services or any other person will be accepted.
- 2) Referrals may be made anonymously.
- 3) All referrals, other than anonymous referrals, will be acknowledged, either in writing, by telephone, by e-mail or in person, within 30 calendar days after receipt of the referral.

## c) Evaluations

- 1) All referrals of suspected fraud or abuse will be evaluated within 60 calendar days after receipt of the referral to determine what, if any, follow up action is appropriate.
- 2) Factors considered during the evaluation of any referral include, but are not limited to:
  - A) source of the allegation;
  - B) quality of the evidence of wrongdoing;

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- C) potential loss to the program; and
  - D) availability of investigative and other resources necessary for successful follow up on the referral.
- 3) Follow up actions include, but are not limited to, the following measures:
- A) When the evaluation identifies possible criminal or civil fraud violations of the Medical Assistance Program or the Children's Health InsuranceKidCare Program or the Covering All Kids Health Insurance Program by a medical provider or contractor, the referral shall be sent to the Medicaid Fraud Control Unit of the Illinois State Police for its review for possible criminal investigation.
  - B) When the evaluation identifies possible criminal or civil fraud violations of any program by a recipient of services or other private citizen and is eligible for follow up action, the Office of Inspector General may initiate an investigation. Should the investigation establish evidence of a criminal or civil fraud violation, the case may be referred to the appropriate United States Attorney, the Office of Attorney General or the appropriate State's Attorney for prosecutorial consideration.
  - C) When the evaluation identifies possible administrative violation and is eligible for follow up action, the Office of Inspector General may initiate a review to determine the appropriate administrative action. Administrative actions include, but are not limited to:
    - i) claims analysis;
    - ii) audit;
    - iii) peer review;
    - iv) recipient restriction;
    - v) eligibility review; or
    - vi) administrative hearing.

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(Source: Amended at 37 Ill. Reg. 10152, effective June 27, 2013)

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- 1) Heading of the Part: Practice in Administrative Hearings
- 2) Code Citation: 89 Ill. Adm. Code 104
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
104.74	New Section
104.75	New Section
104.206	Amendment
104.208	Amendment
104.221	Amendment
104.244	Amendment
104.272	Amendment
104.274	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendments, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: February 1, 2013; 37 Ill. Reg. 922
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: The following changes have been made:
  - In subsection 104.74(a) of Part 104, added "Effective July 1, 2012".
  - In subsection 104.75(a) of Part 104, added "Effective July 1, 2012".
  - In subsections 104.208(a), (b) and (g) of Part 104, added "Effective July 1, 2012".
  - In subsections 104.221(c) and (h) of Part 104, "Effective July 1, 2012".

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In subsection 104.244(a) added "Effective July 1, 2012".

In subsections 104.272(a) and (l) added "Effective July 1, 2012".

- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? Yes, July 13, 2012; 36 Ill. Reg. 10195.
- 14) Are there any other rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: Part 104 is being amended to comply with the SMART Act, PA 97-689.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

The full text of the Adopted Amendments begins on the next page:

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## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## SUBCHAPTER a: GENERAL PROVISIONS

## PART 104

## PRACTICE IN ADMINISTRATIVE HEARINGS

## SUBPART A: ASSISTANCE APPEALS

## Section

104.1	Assistance Appeals
104.10	Initiation of Appeal Process
104.11	Pre-Appeal Review
104.12	Notice of Hearing
104.20	Conduct of Hearings
104.21	Representation
104.22	Appellant Participation in Hearing
104.23	Evidentiary Requirements
104.30	Subpoenas
104.35	Amendment of Appeal
104.40	Consolidation of Appeals
104.45	Postponement or Continuation of Hearings
104.50	Withdrawal of Appeal
104.55	Closing of Hearing Record
104.60	Dismissal of Appeal
104.70	Final Administrative Decision
<a href="#">104.74</a>	<a href="#">Surety Bonds</a>
<a href="#">104.75</a>	<a href="#">Immediate Suspension of a Vendor</a>
104.80	Public Aid Committee

## SUBPART B: RESPONSIBLE RELATIVE AND JOINT PAYEE PETITIONS

## Section

104.100	Support Order, Responsible Relative and Joint Payee Petitions
104.101	Petition for Hearing
104.102	Conduct of Administrative Support Hearings
104.103	Conduct of Hearings to Contest the Determination of Past-Due Support or of a Failure of a Licensee to Comply with a Subpoena or Warrant in a Paternity or Child Support Proceeding or of Share of Jointly-Owned Federal or State Income

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- Tax Refunds or Other Joint Federal or State Payments  
104.104 Conduct of Other Hearings  
104.105 Conduct of Hearings on Petitions for Release from Administrative Paternity Orders  
104.106 Conduct of Hearings on Petitions for Family Financial Responsibility Driving Permits  
104.110 Conduct of Hearings on Joint Owner's Contest of Levy of Jointly-Owned Personal Property

## SUBPART C: MEDICAL VENDOR AND ALTERNATE PAYEE HEARINGS

- Section  
104.200 Applicability  
104.202 Definitions  
104.204 Notice of Denial of An Application  
104.206 Notice of Intent to Recover Money  
104.207 Notice of Contested Paternity Hearing  
104.208 Notice of Intent to Terminate, Suspend, Exclude or Not Renew Provider Agreement or to Revoke Alternate Payee  
104.209 Notice of Intent to Certify Past-Due Support Owed by a Responsible Relative to, or Failure to Comply with a Subpoena or Warrant from, a State Licensing Agency and to Take Disciplinary Action (Repealed)  
104.210 Right to Hearing  
104.211 Notice of Termination or Suspension Pursuant to Exclusion by the Department of Health and Human Services  
104.212 Prior Factual Determinations  
104.213 Demand for Judicial Determination of the Existence of the Father and Child Relationship  
104.215 Notice of Formal Conference  
104.216 Formal Conference on Recovery of Money  
104.217 Purpose of Formal Conference  
104.220 Notice of Hearing  
104.221 Issues at Hearings  
104.225 Legal Counsel  
104.226 Appearance of Attorney or Other Representative  
104.230 Notice, Service and Proof of Service  
104.231 Form of Papers  
104.235 Discovery  
104.240 Conduct of Hearings

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104.241	Amendments
104.242	Motions
104.243	Subpoenas
104.244	Burden of Proof
104.245	Witness at Hearings
104.246	Evidence at Hearings
104.247	Cross-Examination
104.248	Disqualification of Hearing Officers
104.249	Genetic Testing in Contested Paternity Hearings
104.250	Official Notice
104.255	Computer Generated Documents
104.260	Recommendation of Peer Review Committee
104.270	Time Limits for Hearings
104.271	Continuances and Extensions
104.272	Withholding of Payments <u>and Release of Withholds</u> <del>During Pendency of</del> <u>Proceedings</u>
104.273	Continuation of Payments During Pendency of Proceedings
104.274	Denial of Payments for Services During Pendency of Proceedings
104.280	Record of Hearings
104.285	Failure to Appear or Proceed
104.290	Recommended Decision
104.295	Director's Decision

SUBPART D: RULES FOR JOINT DEPARTMENT ACTIONS AGAINST  
SKILLED NURSING FACILITIES AND INTERMEDIATE CARE  
FACILITIES PARTICIPATING IN THE MEDICAID PROGRAM

Section	
104.300	Authority
104.302	Definitions
104.304	Department Actions Against Nursing Homes Facilities
104.310	Certification
104.320	Joint Administrative Hearing
104.330	Facilities Certified Under Both Medicare and Medicaid

## SUBPART E: FOOD STAMP ADMINISTRATIVE DISQUALIFICATION HEARINGS

Section	
104.400	Suspected Intentional Violation of the Program

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AUTHORITY: Implementing Sections 11-8 through 11-8.7, 12-4.9 and 12-4.25 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/11-8 through 11-8.7, 12-4.9, 12-4.25 and 12-13].

SOURCE: Filed and effective December 30, 1977; emergency rule at 2 Ill. Reg. 11, p. 151, effective March 9, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 21, p. 10, effective May 26, 1978; amended at 2 Ill. Reg. 33, p. 57, effective August 17, 1978; peremptory amendment at 3 Ill. Reg. 11, p. 38, effective March 1, 1979; amended at 4 Ill. Reg. 21, p.80, effective May 8, 1980; peremptory amendment at 5 Ill. Reg. 1197, effective January 23, 1981; amended at 5 Ill. Reg. 10753, effective October 1, 1981; amended at 6 Ill. Reg. 894, effective January 7, 1982; codified at 7 Ill. Reg. 5706; amended at 8 Ill. Reg. 5274, effective April 9, 1984; amended (by adding Sections being codified with no substantive change) at 8 Ill. Reg.

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16979; amended at 8 Ill. Reg. 18114, effective September 21, 1984; amended at 10 Ill. Reg. 10129, effective June 1, 1986; amended at 11 Ill. Reg. 9213, effective April 30, 1987; amended at 12 Ill. Reg. 9142, effective May 16, 1988; amended at 13 Ill. Reg. 3944, effective March 10, 1989; amended at 13 Ill. Reg. 17013, effective October 16, 1989; amended at 14 Ill. Reg. 18836, effective November 9, 1990; amended at 15 Ill. Reg. 5320, effective April 1, 1991; amended at 15 Ill. Reg. 6557, effective April 30, 1991; amended at 16 Ill. Reg. 12903, effective August 15, 1992; amended at 16 Ill. Reg. 16632, effective October 23, 1992; amended at 16 Ill. Reg. 18834, effective December 1, 1992; emergency amendment at 17 Ill. Reg. 659, effective January 7, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 7025, effective April 30, 1993; amended at 18 Ill. Reg. 11260, effective July 1, 1994; amended at 19 Ill. Reg. 1321, effective January 30, 1995; emergency amendment at 19 Ill. Reg. 10268, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 15521, effective October 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15711, effective November 6, 1995; amended at 20 Ill. Reg. 1229, effective December 29, 1995; amended at 20 Ill. Reg. 5699, effective March 28, 1996; amended at 20 Ill. Reg. 14891, effective November 1, 1996; emergency amendment at 21 Ill. Reg. 8671, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9306, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13648, effective October 1, 1997; amended at 21 Ill. Reg. 14977, effective November 7, 1997; emergency amendment at 22 Ill. Reg. 17113, effective September 10, 1998, for a maximum of 150 days; amended at 23 Ill. Reg. 2393, effective January 22, 1999; emergency amendment at 23 Ill. Reg. 11734, effective September 1, 1999, for a maximum of 150 days; amended at 24 Ill. Reg. 2418, effective January 27, 2000; amended at 25 Ill. Reg. 5351, effective April 1, 2001; amended at 26 Ill. Reg. 9836, effective June 26, 2002; emergency amendment at 26 Ill. Reg. 11022, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 12306, effective July 26, 2002; amended at 26 Ill. Reg. 17743, effective November 27, 2002; amended at 27 Ill. Reg. 5853, effective March 24, 2003; amended at 27 Ill. Reg. 13771, effective August 1, 2003; amended at 28 Ill. Reg. 2735, effective February 1, 2004; emergency amendment at 29 Ill. Reg. 2735, effective February 7, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 10187, effective June 30, 2005; amended at 31 Ill. Reg. 2387, effective January 19, 2007; amended at 32 Ill. Reg. 16797, effective October 6, 2008; amended at 33 Ill. Reg. 6283, effective April 15, 2009; amended at 35 Ill. Reg. 2030, effective January 21, 2011; amended at 35 Ill. Reg. 12900, effective July 25, 2011; amended at 36 Ill. Reg. 7530, effective May 7, 2012; amended at 36 Ill. Reg. 9086, effective June 11, 2012; emergency amendment at 36 Ill. Reg. 10195, effective July 1, 2012 through June 30, 2013; amended at 37 Ill. Reg. 10172, effective June 27, 2013.

## SUBPART A: ASSISTANCE APPEALS

**Section 104.74 Surety Bonds**

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- a) Effective July 1, 2012, the following individuals and entities may be required to post a surety bond as part of a condition of enrollment or participation in the Medical Assistance Program:
- 1) a vendor or a prior vendor who has been terminated, excluded or suspended from the Medical Assistance Program, or from another state or federal medical assistance or health care program;
  - 2) any individual currently or previously barred from the Medical Assistance Program, or from another state or federal medical assistance or health care program, as a result of being an officer or a person owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor during the time of any conduct that served as the basis for that vendor's termination, suspension or exclusion;
  - 3) a vendor or a prior vendor who has a debt owed to the Department;
  - 4) any individual currently or previously barred from the Medical Assistance Program, or from another state or federal medical assistance or health care program, as a result of being an officer or a person owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in that corporate or limited liability company vendor who has a debt owed to the Department, when the individual was in that position during the time of any conduct that served as the basis for the vendor's debt; or
  - 5) vendors, individuals or entities that demonstrated previous poor performance or conduct who pose a risk of fraud, waste, abuse or harm, as defined in 89 Ill. Adm. Code 140.13.
- b) When required by the Department, the value of surety bond shall be based on:
- 1) the potential for loss to the Department;
  - 2) the value of claims historically submitted by the individual or entity to the Department, or to another state or federal medical assistance or health care program;

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- 3) the previous performance and conduct of the individual or entity; and
  - 4) when a debt is owed the Department, the amount of the debt.
- c) As used in this Section, "surety bond" means a bond executed by the individual or entity for enrollment or participation in the Medical Assistance Program and a person or firm authorized to conduct surety business in Illinois that obligates the guarantor to pay the Department or its designee upon default by the individual or entity in the performance of any duty the individual or entity owes to the Department or a third party.

(Source: Added at 37 Ill. Reg. 10172, effective June 27, 2013)

**Section 104.75 Immediate Suspension of a Vendor**

- a) Effective July 1, 2012, anything in this Part to the contrary notwithstanding, upon making a determination based upon information in the possession of the Department that continuation of participation in the Medical Assistance Program by a vendor would constitute an immediate danger to the public, the Department may immediately suspend the vendor's participation in the Medical Assistance Program without a prior hearing.
- b) In instances in which the Department immediately suspends the Medical Assistance Program participation of a vendor under subsection (a):
  - 1) The Department shall notify the vendor of the action in writing.
  - 2) A hearing upon the vendor's participation shall be convened by the Department within 15 days after suspension and completed without appreciable delay.
  - 3) The sole issue at hearing shall be held to determine whether to recommend to the Department Director that the vendor's Medical Assistance Program participation be denied, terminated, suspended, placed on provisional status or reinstated.
  - 4) The standard of proof at the hearing shall be a preponderance of the evidence.

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- 5) Any evidence relevant to the vendor constituting an immediate danger to the public may be introduced against the vendor. The vendor, or his or her counsel, shall have the opportunity to discredit, impeach and submit evidence rebutting the evidence.

(Source: Added at 37 Ill. Reg. 10172, effective June 27, 2013)

## SUBPART C: MEDICAL VENDOR AND ALTERNATE PAYEE HEARINGS

**Section 104.206 Notice of Intent to Recover Money**

## a) Institutional Vendors

- 1) For purposes of this Section, institutional vendors means providers enrolled in the Medical Assistance Program to provide inpatient or residential services, such as hospitals and long term care facilities.
- 2) The Department shall notify the institutional vendor in writing of an intent to recover money, setting forth:
  - A) the reason for the Department's action;
  - B) a statement of the right to request a hearing;
  - C) a statement of the time, place and nature of the hearing;
  - D) a statement of the legal authority and jurisdiction under which the hearing is to be held; and
  - E) a reference to the Sections of the statutes and rules involved.
- 3) For institutional vendors, the Department will not recover money prior to the issuance of a final administrative decision, unless the Department determines that the recovery of money would be in jeopardy if the recovery does not occur prior to the completion of the hearing due to events such as, but not limited to, pending decertification of the provider or the filing of a False Claims Act (31 USC 3729) action against the provider. In ~~thesesuch~~ circumstances, the Department may recover the

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money prior to the completion of the hearing, and the notice shall set forth:

- A) the date after which the Department will start to recover money by deducting from Department obligations to the vendor;
- B) a statement that the Department will recover the money in this manner prior to the completion of any hearing requested;
- C) a statement that any money so recovered will be repaid to the vendor if it is determined at hearing that the recovery was not warranted; and
- D) a statement that the vendor has the opportunity to respond prior to the date the Department will start to recover money during the pendency of the hearing and a statement of how and to whom such a response should be made.

- 4) Nothing in this subsection (a), except as provided in subsection (a)(3), shall preclude a vendor who is enrolled to provide inpatient or residential services from voluntarily having the Department recover money by deducting from Department obligations to the vendor all or part of the claimed overpayment prior to the completion of any hearing.

b) Noninstitutional Vendors

- 1) For purposes of this Section, noninstitutional vendors means providers enrolled in the Medical Assistance Program that do not provide inpatient or residential services.
- 2) The Department shall notify the noninstitutional vendor in writing of an intent to recover money setting forth:
  - A) the requirements described in ~~subsection (a)(2) through (E) of this Section;~~ ~~subsections (a)(2);(A)~~
  - B) the date after which the Department will start to recover money by deducting from Department obligations to the vendor;

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- C) a statement that the Department will recover the money in this manner prior to the completion of any hearing requested;~~;~~
- D) a statement that any money so recovered will be repaid to the vendor if it is determined at hearing that the recovery was not warranted;~~;~~ and
- E) a statement that the vendor has the opportunity to respond prior to the date the Department will start to recover money during the pendency of the hearing and a statement of how and to whom such a response should be made.
- c) Alternate Payee  
The Department shall notify the alternate payee in writing of an intent to suspend or deny payment or to recover money, setting forth:
- 1) the requirements described in ~~subsections~~ subsections (a)(2); ~~(A) through (E) of this Section;~~
  - 2) the date after which the Department will start to suspend, deny or recover money by deducting from Department obligations to the alternate payee;~~;~~
  - 3) a statement that the Department will suspend, deny or recover the money in this manner prior to the completion of any hearing requested;~~;~~
  - 4) a statement that any money so suspended, denied or recovered will be repaid to the alternate payee if it is determined at hearing that the suspension, denial or recovery was not warranted;~~;~~ and
  - 5) a statement that the alternate payee has the opportunity to respond prior to the date the Department will start to suspend, deny or recover money during the pendency of the hearing and a statement of how and to whom ~~such~~ a response should be made.
- d) Recovery of Interest
- 1) The Department may shall recover interest on the amount of an overpayment or other benefit authorized under Article V of the Public Aid Code at the rate of five percent per annum if it is established through an

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administrative hearing that the overpayment resulted from the institutional or noninstitutional vendor or alternate payee ~~knowingly willfully~~ making, ~~using~~, or causing to be made ~~or used~~, a false ~~record or statement to obtain payment or other benefit from the Medical Assistance Program~~ or ~~misrepresentation of a material fact in connection with billings and payments under the medical assistance program.~~

2) In addition to any other factors it deems appropriate, the HFS Office of Inspector General, in its sole discretion, shall consider the following factors when determining whether to collect interest from a provider paid an overpayment:

- A) the egregiousness of the conduct, including the duration, severity and volume of claims billed to the Department;
- B) the best interest of the recipients of medical assistance; and
- C) the provider's history with the Department, including previous audit determinations.

3)2) The Department shall notify the institutional or noninstitutional vendor or alternate payee in writing of its intent to recover interest on the amount of overpayment by setting forth:

- A) the requirements described in ~~subsections~~ subsections (a)(2);~~(A) through (E) of this Section;~~
- B) a statement of the amount of overpayment ~~or other medical assistance benefit~~ subject to recovery of interest;
- C) a statement of the amount of interest as of the date of notice;
- D) a statement that the amount of interest may continue to accrue until ~~such time as~~ the amount of overpayment ~~or other medical assistance benefit~~ subject to interest has been paid;
- E) a statement that any amounts withheld pursuant to Section 104.272 shall first be applied to the amount not subject to the interest provisions of this subsection (c). If the amounts subject to

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recovery of interest are withheld, the interest will be adjusted to reflect the withholding<sup>5</sup>; and

- F) a statement that any money so recovered will be repaid to the vendor if it is determined at hearing that the recovery was not warranted.
- e) Nothing in this Section shall preclude a vendor or alternate payee from voluntarily paying the amount of interest or having the Department recover the interest by deducting from Department obligations to the vendor prior to completion of the hearing. If the vendor or alternate payee has voluntarily paid the amount of overpayment subject to recovery of interest prior to the issuance of a final administrative decision, the amount of interest will cease to accrue.

(Source: Amended at 37 Ill. Reg. 10172, effective June 27, 2013)

**Section 104.208 Notice of Intent to Terminate, Suspend, Exclude or Not Renew Provider Agreement or to Revoke Alternate Payee**

- a) Effective July 1, 2012, except~~Except~~ for actions brought jointly by the Department of Healthcare and Family Services and the Department of Public Health pursuant to Section 104.300, the following provisions apply. If, in an action other than one under 89 Ill. Adm. Code 140.16(a)(2), ~~or one~~ under 89 Ill. Adm. Code 140.16(a)(~~109~~) based on a conviction for a violation of applicable federal or state law or regulation~~the Illinois Public Aid Code, or under 89 Ill. Adm. Code 140.16(c)~~, the Department intends to terminate, ~~or~~ suspend or exclude a vendor's eligibility to participate in the Medical Assistance Program, or terminate (or not renew) a vendor's provider agreement, it shall notify the vendor in writing, setting forth:
- 1) the reason for the Department's action<sup>5</sup>;
  - 2) a statement of the right to request a hearing prior to the intended action taking effect<sup>5</sup>;
  - 3) a statement of the time, place and nature of the hearing<sup>5</sup>;
  - 4) a statement of the legal authority and jurisdiction under which the hearing is to be held<sup>5</sup>; and

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- 5) a reference to the provisions of the statutes and rules involved.
- b) ~~Effective July 1, 2012, except~~~~Except~~ for actions brought jointly by the Department of Healthcare and Family Services and the Department of Public Health pursuant to Section 104.300, the following provisions apply. If, in an action under 89 Ill. Adm. Code 140.16(a)(2), under 89 Ill. Adm. Code 140.16(a)(10) based on a conviction for a violation of applicable federal or state law or regulation, or under 89 Ill. Adm. Code 140.16(c), except in an action initiated pursuant to Section 104.211, ~~an action under 89 Ill. Adm. Code 140.16(a)(9) based on a conviction for a violation of the Illinois Public Aid Code, or an action brought against a non-emergency transportation vendor under 89 Ill. Adm. Code 140.16(a)~~, the Department intends to terminate, ~~or~~ suspend or exclude a vendor's eligibility to participate in the Medical Assistance Program, or terminate (or not renew) a vendor's provider agreement, it shall notify the vendor in writing, setting forth:
- 1) the reason for the Departments' action<sub>35</sub>
  - 2) the effective date of the action<sub>35</sub>
  - 3) a statement that the vendor has the opportunity to respond prior to the effective date and a statement of how and to whom such a response should be made<sub>35</sub>
  - 4) a statement that the action will be effective on ~~that~~~~such~~ date regardless of whether any hearing requested has been completed<sub>35</sub>
  - 5) a statement of the right to request a hearing<sub>35</sub>
  - 6) a statement of the time, place and nature of the hearing<sub>35</sub>
  - 7) a statement of the legal authority and jurisdiction under which the hearing is to be held<sub>35</sub> and
  - 8) a reference to the provisions of the statutes and rules involved.
- c) In an action brought jointly against a nursing home (not an ICF/~~DDMR~~ facility) by the ~~Illinois~~ Department of Healthcare and Family Services and the ~~Illinois~~

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Department of Public Health pursuant to Section 104.300 in which the Department of Healthcare and Family Services intends to terminate, suspend or deny the provider agreement, and the Department of Public Health intends to deny certification, the Departments shall notify the vendor in writing, setting forth:

- 1) the reason for the Departments' action<sub>3,5</sub>
  - 2) the effective date of the action<sub>3,5</sub>
  - 3) a statement that the vendor has an opportunity to respond prior to the effective date and a statement of how and to whom such a response should be made<sub>3,5</sub>
  - 4) a statement that the action will be effective on that date regardless of whether any hearing requested has been completed<sub>3,5</sub>
  - 5) a statement of the right to request a hearing<sub>3,5</sub>
  - 6) a statement that a hearing will be scheduled to take place within 30 days after receipt of a request for hearing<sub>3,5</sub>
  - 7) a statement of the legal authority and jurisdiction under which the hearing is to be held<sub>3,5</sub> and
  - 8) a reference to the Sections of the statutes and rules involved.
- d) In an action brought jointly against an ICF/DDMR facility by the Illinois Department of Healthcare and Family Services and the Illinois-Department of Public Health pursuant to Section 104.300 in which the Department of Healthcare and Family Services intends to terminate, suspend or deny the provider agreement, and the Department of Public Health intends to deny certification, the Departments shall notify the vendor in writing, setting forth:
- 1) the reason for the Departments' action<sub>3,5</sub>
  - 2) a statement of the right to request a hearing prior to the intended action taking effect<sub>3,5</sub>

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- 3) a statement that a hearing will be scheduled to take place within 30 days after receipt of a request for hearing~~;~~
  - 4) a statement of the legal authority and jurisdiction under which the hearing is to be held~~;~~ and
  - 5) a reference to the provisions of the statutes and rules involved.
- e) In an action in which the Department intends to seek revocation of an alternate payee in the Medical Assistance Program, it shall notify the alternate payee in writing, setting forth:
- 1) the reason for the Department's action~~;~~
  - 2) a statement of the right to request a hearing prior to the intended action taking effect~~;~~
  - 3) a statement of the time, place and nature of the hearing~~;~~
  - 4) a statement of the legal authority and jurisdiction under which the hearing is to be held~~;~~ and
  - 5) a reference to the provisions of the statutes and rules involved.
- f) The notice shall also inform the vendor, ~~when~~where applicable, that the final administrative decision of the Department could result in suspension for a specific period of time as well as termination.
- g) Effective July 1, 2012, for actions of the Department for the purpose of immediate suspension of a provider pursuant to Section 104.75, the Department shall notify the vendor in writing, setting forth:
- 1) the reason for the Department's action;
  - 2) the effective date of the action;
  - 3) a statement that the action will be effective on that date regardless of whether any hearing requested has been completed;

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- 4) a statement of the time, place and nature of the hearing;
- 5) that the purpose of the hearing shall be to determine whether to recommend to the Director that the vendor's medical assistance program participation be denied, terminated, suspended, placed on provisional status or reinstated;
- 6) a statement of the legal authority and jurisdiction under which the hearing is to be held; and
- 7) a reference to the provisions of the statutes and rules involved.

(Source: Amended at 37 Ill. Reg. 10172, effective June 27, 2013)

**Section 104.221 Issues at Hearings**

- a) The sole issue at a hearing in which the basis for denial of an application pursuant to 89 Ill. Adm. Code 140.14(d) is that the vendor does not have a necessary license, certificate or authorization shall be whether the vendor has such a license, certificate or authorization.
- b) The sole issue at a hearing in which the basis of the denial of an application is as set forth in 89 Ill. Adm. Code 140.14(b) shall be whether the vendor has demonstrated, according to the factors listed in that Section, in light of the prior activities, that he or she should be admitted to the Medical Assistance Program.
- c) Effective July 1, 2012, the only issues at a hearing in which the basis of the denial of an application is as set forth in:
  - 1) 89 Ill. Adm. Code 140.14(e)(1) shall be whether the applicant or any person with management responsibility for the applicant, an officer or member of the board of directors of the applicant, an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant, an owner of a sole proprietorship applicant, a partner in a partnership applicant, or a technical or other advisor to the applicant has a debt owed to the Department and/or whether payment arrangements acceptable to the Department have been made by the applicant.

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- 2) 89 Ill. Adm. Code 140.14(e)(2) shall be whether the applicant or any person with management responsibility for the applicant, an officer or member of the board of directors of the applicant, an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant, an owner of a sole proprietorship applicant, a partner in a partnership vendor applicant, or a technical or other advisor to the applicant was a person with management responsibility, an officer or member of the board of directors of an applicant, an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship, a partner in a partnership vendor, or a technical or other advisor to a vendor during the period of time when the conduct of that vendor resulted in a debt owed to the Department and/or whether payment arrangements acceptable to the Department have been made by that vendor.
- 3) 89 Ill. Adm. Code 140.14(e)(3) shall be whether the allegation of the use, transfer or lease of assets of any kind to the applicant from a current or prior vendor who has a debt owed to the Department is credible, whether payment arrangements acceptable to the Department have been made by that vendor or the vendor's alternate payee, and/or whether the applicant knows or should have known of the debt.
- 4) 89 Ill. Adm. Code 140.14(e)(4) shall be whether the allegation of a transfer of management responsibilities, or direct or indirect ownership, to an applicant from a current or prior vendor who has a debt owed to the Department is credible, whether payment arrangements acceptable to the Department have been made by that vendor or the vendor's alternate payee, and/or whether the applicant knows or should have known of the debt.
- 5) 89 Ill. Adm. Code 140.14(e)(5) shall be whether the allegation of the use, transfer or lease of assets of any kind to an applicant who is a spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, relative by marriage, or relative of a current or prior vendor who has a debt owed to the Department is credible and/or whether payment arrangements acceptable to the Department have been made.

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- 6) 89 Ill. Adm. Code 140.14(e)(6) shall be whether the allegation that the applicant's previous affiliations with a provider of medical services that has an uncollected debt, a provider that has been or is subject to a payment suspension under a federal health care program, or a provider that has been previously excluded from participation in the Medical Assistance Program poses a risk of fraud, waste or abuse to the Department is credible.
- d)e) The sole issue at a hearing in which the basis for termination is as set forth in 89 Ill. Adm. Code 140.16(a)(2) shall be whether the appropriate licensing, certifying or authorizing agency has determined that the vendor does not have a necessary license, certification or authorization.
- e)d) The sole issue at a hearing requested by a previously suspended vendor that is being terminated pursuant to 89 Ill. Adm. Code 140.19(b) shall be whether the vendor has corrected the deficiencies on which the suspension was based.
- f)e) At a hearing conducted pursuant to Subpart D of this Part, the sole relevant time with respect to the existence of the violations of the Department's requirements alleged in the notice shall be the date or dates in the notice.
- g)f) The only issue at a hearing initiated pursuant to 89 Ill. Adm. Code 140.16(c) is whether the vendor is not in compliance with State income tax requirements, child support requirements of Article X of the Public Aid Code, or educational loans guaranteed by the Illinois Student Assistance Commission.
- h) Effective July 1, 2012, the sole issue at a hearing requested by a person or entity with a debt due the State pursuant to Section 12-4.25(F-15)(3) of the Public Aid Code shall be whether the person or entity has failed to comply with judgment on which the debt is based.

(Source: Amended at 37 Ill. Reg. 10172, effective June 27, 2013)

**Section 104.244 Burden of Proof**

- a) Effective July 1, 2012, theThe burden of proof in hearings conducted pursuant to 89 Ill. Adm. Code 140.14 shall be on the Department if the application was denied because the vendor engaged in activities that constitute grounds for termination or was denied pursuant to 89 Ill. Adm. Code 140.14(c). The burden of

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proof shall be on the applicant if the application was denied because of:

- 1) a determination that a previously terminated or barred vendor cannot reasonably be expected to meet the requirements of the Department; ~~or~~
  - 2) a determination that, based on the activities that served as the basis for terminating or barring a vendor, the application should not be approved; or-
  - 3) denial of the eligibility of the applicant pursuant to 89 Ill. Adm. Code 140.14(e).
- b) The burden of proof in hearings conducted pursuant to 89 Ill. Adm. Code 140.15 or Subpart D of this Part shall be on the Department.
  - c) The burden of proof in hearings conducted pursuant to 89 Ill. Adm. Code 140.16 shall be on the Department.
  - d) The burden of proof in hearings conducted pursuant to 89 Ill. Adm. Code 140.32 shall be on the party seeking special permission, and in hearings conducted pursuant to 89 Ill. Adm. Code 140.19(b) shall be on the vendor.
  - e) In the case of any new matter introduced in connection with any affirmative defense, the burden of proof with respect to that new matter shall be upon the party that alleges the new matter.
  - f) The standard of proof with respect to all hearings conducted pursuant to this Part shall be a preponderance of the evidence.

(Source: Amended at 37 Ill. Reg. 10172, effective June 27, 2013)

**Section 104.272 Withholding of Payments and Release of Withholds During Pendency of Proceedings**

- a) Effective July 1, 2012, payments to any vendor or alternate payee ~~Payments~~ on pending and subsequently submitted bills may be withheld prior to or during the pendency of any audit, administrative appeal or administrative review proceeding by any court ~~the administrative proceeding:~~

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- 1) In which~~Where~~:
    - A) the administrative proceeding seeks the termination, exclusion or suspension of the provider or revocation of the alternate payee; or
    - B) the administrative hearing is seeking recovery of money and the recovery is at risk due to the financial or other circumstances of the provider or the alternate payee.
  - 2) In which~~Where~~ the administrative proceeding is seeking recovery of money only, the withholding shall be limited to the amount sought in the recovery and in conformance with Section 104.273.
- b) A provider or alternate payee may request a full or partial release of withheld payments. The provider must submit a request, in writing, setting forth the reasons the payments should be released, to the Office of Inspector General at either 404 North Fifth Street, Springfield, Illinois 62702, or by e-mail to [HFS.OIGWebmaster@illinois.gov](mailto:HFS.OIGWebmaster@illinois.gov)~~Oigwebmaster@illinois.gov.state.il.us~~. The request should set forth the reasons for the request in conformance with subsection (c) of this Section.
- c) Partial or full release of payments on pending and subsequently submitted bills may be granted, at the discretion of the Inspector General of the Department, based on the following factors:
- 1) The Department has not proceeded in a timely manner in presentation of its case in the administrative proceeding, including, but not limited to, lengthy delays in the availability of Department witnesses, attorneys or Administrative Law Judges.
  - 2) When~~Where~~ it is in the best interests of the recipients of medical assistance. This may include, but is not limited to, access to medical services for recipients or the potential movement of patients from long term care settings.
  - 3) When~~Where~~, based on the reasons for the initiation of the proceeding, the full or partial release of payments would not be, in the judgment of the Inspector General, detrimental to the recipients or the Department.

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- 4) Whether the provider or alternate payee has caused delays in proceeding in a timely manner, including, but not limited to, delays in the availability of witnesses or attorneys.
- d) The Inspector General will notify the provider or alternate payee in writing of the decision on the request for release of payments.
  - e) Payments on pending and subsequently submitted bills will not be released if:
    - 1) The basis for the termination, exclusion, suspension or revocation is a criminal conviction.
    - 2) The basis for the termination, exclusion, suspension or revocation is the termination, revocation or denial of a professional license or certification.
    - 3) The provider or alternate payee has had payments suspended pursuant to Section ~~305 ILCS 5/12-4.25(K)~~ or (K-5) of the Public Aid Code or 42 CFR 455.23.
    - 4) The provider or alternate payee has had payments suspended pursuant to Section ~~305 ILCS 5/12-4.25(F-5)~~ of the Public Aid Code.
  - f) The Inspector General may release partial payment when, in the judgment of the Inspector General, full release of payments is not warranted pursuant to subsection (b) of this Section, but a partial release would meet these criteria.
  - g) The Inspector General may again institute full or partial withholding of payments after a full or partial release of payments if:
    - 1) The provider or alternate payee has not proceeded in a timely manner in presentation of its case in the administrative proceeding, including, but not limited to, lengthy delays in the availability of witnesses or attorneys.
    - 2) The provider's or alternate payee's professional license or certification has been revoked, suspended, denied or otherwise not renewed.
  - h) If the provider is terminated, excluded or suspended, or the alternate payee is revoked, as a result of final agency action, payments or credit for any services rendered subsequent to receipt of the notice of intent to terminate, after a final

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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decision has been rendered, or after the conclusion of any administrative appeal, shall be denied. The provider or alternate payee will receive payment or credit for services rendered prior to receipt of the notice of intent to terminate, exclude, suspend or revoke subject to setoff for recovery of the amount sought in the proceeding.

- i) If the payments have been suspended pursuant to Section 305 ILCS 5/12-4.25(F-5) of the Public Aid Code and the indictment or charge results in conviction, all withheld payments shall be considered forfeited to the Department. If the indictment or charge does not result in conviction, payments pending and subsequently submitted bills will be released, unless the provider is involved in any other proceeding in which payments are being withheld.
- j) If the provider or alternate payee is convicted of ana felony offense of the type described in Section 305 ILCS 5/12-4.25(F-5) of the Public Aid Code, the Department may withhold payments from the provider or alternate payee from the date of conviction until the date the provider or alternate payee receives a notice of intent to terminate, exclude, suspend or revoke. Once the provider or alternate payee receives a notice of intent to terminate, exclude, suspend or revoke, the Department may continue to withhold payments during the pendency of the administrative proceeding.
- k) If payments have been withheld pursuant to Section 305 ILCS 5/12-4.25(K) or (K-5) of the Public Aid Code, 42 CFR 455.23, or 89 Ill. Adm. Code 140.44, and the Department commences an administrative proceeding that seeks the termination, exclusion or suspension of the provider or revocation of the alternate payee, the Department shall continue to withhold payments during the pendency of the administrative proceeding. If the provider is terminated, excluded or suspended, or the alternate payee is revoked, as a result of final agency action, the withheld payments shall be denied.
- l) Effective July 1, 2012, the Department may withhold payments to any vendor or alternate payee who is not properly licensed, certified or in compliance with State or federal agency regulations. Payments may be denied for bills submitted with service dates occurring during the period of time that a vendor is not properly licensed, certified or in compliance with State or federal regulations; provided, however, that facilities licensed under the Nursing Home Care Act [210 ILCS 45] shall have payments denied or withheld pursuant to Section 12-4.25(I) of the Public Aid Code.

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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(Source: Amended at 37 Ill. Reg. 10172, effective June 27, 2013)

**Section 104.274 Denial of Payments for Services During Pendency of Proceedings**

If the vendor is terminated, suspended or excluded, or the alternate payee is revoked, as a result of final agency action, payments or credit for any services rendered subsequent to receipt of the notice of intent to terminate, suspend, exclude or revoke shall be denied unless:

- a) Pursuant to Section 104.273, payments were not withheld; or
- b) Pursuant to Section 104.272, previously withheld payments for such services had been released.

(Source: Amended at 37 Ill. Reg. 10172, effective June 27, 2013)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Application Process
- 2) Code Citation: 89 Ill. Adm. Code 110
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
110.36	Repeal
110.38	Repeal
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendments, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: July 13, 2012; 36 Ill. Reg. 9886
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? Yes, July 13, 2012; 36 Ill. Reg. 10219.
- 14) Are there any other proposed rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: Public Act 97-0689, the Save Medicaid Access and Resources Together (SMART) Act, addresses the significant spending and liability deficits in the Medicaid program. SMART authorizes the elimination of the General Assistance Program.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

The full text of the Adopted Amendments begins on the next page:

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## SUBCHAPTER b: ASSISTANCE PROGRAMS

## PART 110

## APPLICATION PROCESS

## Section

110.1	Incorporation by Reference
110.10	Application for Assistance
110.15	Local Office Action on Application for Public Assistance
110.20	Time Limitations on the Disposition of an Application
110.30	Approval of an Application and Initial Authorization of Financial Assistance
110.32	Initial Authorization of Medical Assistance (MAG)
110.34	Approval of an Application and Initial Authorization of Medical Assistance – (MANG)
110.36	Initial Authorization of General Assistance – Medical <u>(Repealed)</u>
110.38	General Assistance and Aid to the Medically Indigent Special Approval Provisions <u>(Repealed)</u>
110.40	Denial of an Application

AUTHORITY: Implementing Articles III, IV, V, VI and VII and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI, VII and 12-13].

SOURCE: Filed and effective December 30, 1977; emergency amendment at 2 Ill. Reg. 44, p. 167, effective October 19, 1978, for a maximum of 150 days; amended at 3 Ill. Reg. 5, p. 875, effective February 2, 1979; amended at 3 Ill. Reg. 44, p. 173, effective October 19, 1979; amended at 6 Ill. Reg. 8125, effective July 1, 1982; codified at 7 Ill. Reg. 5195; amended at 8 Ill. Reg. 6760, effective May 3, 1984; amended at 9 Ill. Reg. 6798, effective April 30, 1985; amended at 9 Ill. Reg. 13087, effective August 16, 1985; amended at 12 Ill. Reg. 11457, effective July 1, 1988; amended at 13 Ill. Reg. 3836, effective March 10, 1989; amended at 13 Ill. Reg. 10628, effective June 22, 1989; amended at 14 Ill. Reg. 13198, effective August 6, 1990; amended at 16 Ill. Reg. 16618, effective October 23, 1992; amended at 17 Ill. Reg. 640, effective December 31, 1992; emergency amendment at 19 Ill. Reg. 8429, effective June 9, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15053, effective October 17, 1995; amended at 20 Ill. Reg. 14834, effective November 1, 1996; amended at 36 Ill. Reg. 4126, effective March 1, 2012; emergency amendment at 36 Ill. Reg. 10219, effective July 1, 2012 through June 30, 2013; amended at 37 Ill. Reg. 10197, effective June 27, 2013.

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## NOTICE OF ADOPTED AMENDMENTS

**Section 110.36 Initial Authorization of General Assistance – Medical (Repealed)**

~~General Assistance (GA) medical assistance, except for clients determined by the Department to be disabled, shall be authorized, dependent on the specific case situation, effective:~~

- ~~a) The first day of the month of application providing the client was eligible that month; or~~
- ~~b) The first day of the month immediately prior to the month of application; or~~
- ~~c) The first day of the month of initial eligibility subsequent to the month in which application is made.~~

(Source: Repealed at 37 Ill. Reg. 10197, effective June 27, 2013)

**Section 110.38 General Assistance and Aid to the Medically Indigent Special Approval Provisions (Repealed)**

~~Temporary assistance shall be authorized in General Assistance cases in which it is verified that an applicant meets all eligibility criteria other than the requirement of citizenship/alienage status and such verification is expected to be received but to take a length of time which would cause undue hardship to the applicant, such that he would be unable to meet his basic maintenance needs of food, shelter and other necessities and the applicant has submitted verification that the required documents have been requested.~~

(Source: Repealed at 37 Ill. Reg. 10197, effective June 27, 2013)



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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENT

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 118

SPECIAL ELIGIBILITY GROUPS

SUBPART A: DISABLED ADULT CHILDREN

Section  
118.100 Disabled Adult Children

SUBPART B: PERSONS WITH ACQUIRED IMMUNODEFICIENCY  
SYNDROME (AIDS) OR AIDS RELATED COMPLEXES (ARC)

Section  
118.150 Continuation of Health Insurance Coverage  
118.200 Drugs to Prolong the Lives of Persons With Acquired Immunodeficiency  
Syndrome (AIDS) or AIDS Related Complexes (ARC)

SUBPART C: WIDOWS AND WIDOWERS

Section  
118.300 Widows and Widowers

SUBPART D: MISCELLANEOUS PROGRAM PROVISIONS

Section  
118.400 Incorporation by Reference

SUBPART E: CERTAIN NON-CITIZEN CHILDREN

Section  
118.500 Medical Services for Certain Non-Citizen Children

SUBPART F: FAMILYCARE ELIGIBILITY

Section  
| 118.600 Limited FamilyCare Expansion (Repealed)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENT

AUTHORITY: Implementing Articles III, IV, VI and Section 5-18 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI, 5-18 and 12-13].

SOURCE: Emergency rule adopted at 12 Ill. Reg. 3037, effective January 15, 1988, for a maximum of 150 days; adopted at 12 Ill. Reg. 6301, effective March 18, 1988; amended at 12 Ill. Reg. 8068, effective April 26, 1988; amended at 13 Ill. Reg. 3950, effective March 10, 1989; amended at 14 Ill. Reg. 10442, effective June 20, 1990; emergency amendment at 15 Ill. Reg. 8708, effective June 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 11607, effective July 15, 1992; emergency amendment at 17 Ill. Reg. 11217, effective July 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 19956, effective November 12, 1993; amended at 19 Ill. Reg. 7959, effective June 5, 1995; emergency amendment at 22 Ill. Reg. 15724, effective August 12, 1998, for a maximum of 150 days; amended at 23 Ill. Reg. 562, effective December 24, 1998; recodified from Department of Public Aid to the Department of Healthcare and Family Services at 29 Ill. Reg. 5601, effective July 1, 2005; emergency amendment at 30 Ill. Reg. 10129, effective May 17, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 16966, effective October 13, 2006; emergency amendment at 33 Ill. Reg. 10780, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 15702, effective November 2, 2009; emergency amendment at 36 Ill. Reg. 10223, effective July 1, 2012 through June 30, 2013; amended at 37 Ill. Reg. 10201, effective June 27, 2013.

## SUBPART F: FAMILYCARE ELIGIBILITY

**Section 118.600 Limited FamilyCare Expansion (Repealed)**

- a) ~~Caretaker relatives who were enrolled in FamilyCare as of June 30, 2009, as caretaker relatives (see 89 Ill. Adm. Code 120.390), qualify for medical assistance as long as they maintain continuous enrollment, and their countable income is above 185 percent and at or below 400 percent of the Federal Poverty Income Guidelines, as published annually in the Federal Register, for the appropriate family size. All other requirements applicable to caretaker relatives eligible under 89 Ill. Adm. Code 120.34 must be met.~~
- b) ~~If a caretaker relative becomes otherwise eligible for medical assistance under 89 Ill. Adm. Code 120, the provisions of this Section shall no longer apply, and nothing in this Section shall preclude a caretaker relative from otherwise qualifying for medical assistance.~~
- e) ~~Caretaker relatives qualifying under subsection (a) will be covered as follows:~~

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENT

- ~~1) If monthly countable income is above 185 percent and at or below 200 percent of the Federal Poverty Level (FPL) for the number of persons in the family, an eligible caretaker relative will be covered under FamilyCare Premium Level 1.~~
- ~~2) If monthly countable income is above 200 percent and at or below 300 percent of the FPL for the number of persons in the family, an eligible caretaker relative will be covered under FamilyCare Premium Level 2.~~
- ~~3) If monthly countable income is above 300 percent and at or below 400 percent of the FPL for the number of persons in the family, an eligible caretaker relative will be covered under FamilyCare Premium Level 3.~~
- ~~4) Premium amounts will be adjusted to reflect adding or removing an eligible caretaker relative from the case and changes in countable income.~~
- d) ~~Caretaker relatives shall pay premiums as follows:~~
  - ~~1) Caretaker relatives enrolled in FamilyCare Premium Level 1 who are not in families with American Indians or Alaska Natives shall pay premiums as set forth in 89 Ill. Adm. Code 120.34(e).~~
  - ~~2) Caretaker relatives enrolled in FamilyCare Premium Level 2 shall pay premiums of \$80 per person per month.~~
  - ~~3) Caretaker relatives enrolled in FamilyCare Premium Level 3 shall pay premiums of \$140 per person per month.~~
- e) ~~Caretaker relatives enrolled under this Section may receive coverage, and pay the same co-payments, for those medical services available to caretaker relatives eligible under 89 Ill. Adm. Code 120.34.~~
- f) ~~Caretaker relatives enrolled under this Section have appeal rights, as set forth at 89 Ill. Adm. Code 102.80. The provisions of Subpart A of the Department's administrative rules at 89 Ill. Adm. Code 104, Practice in Administrative Hearings, shall govern any appeals under this Subpart F.~~

(Source: Repealed at 37 Ill. Reg. 10201, effective June 27, 2013)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Illinois Cares Rx Program
- 2) Code Citation: 89 Ill. Adm. Code 119
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
119.10	Repeal
119.20	Repeal
119.30	Repeal
119.40	Repeal
119.50	Repeal
119.60	Repeal
119.70	Repeal
119.80	Repeal
119.90	Repeal
119.100	Repeal
119.110	Repeal
119.120	Repeal
119.130	Repeal
- 4) Statutory Authority: Implementing and authorized by PA 97-869
- 5) Effective Date of Repealer: June 27, 2013
- 6) A copy of the adopted rulemaking including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 7) Notice of Proposal published in the *Illinois Register*: July 13, 2012; 36 Ill. Reg. 9890
- 8) Has JCAR issued a Statement of Objection to this repeal? No
- 9) Differences between Proposal and Final Version: None
- 10) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes. None were made.
- 11) Will this repealer replace any emergency repealer currently in effect? Yes, 36 Ill. Reg. 10229; July 13, 2012
- 12) Are there any other rulemakings pending on this Part? No

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED REPEALER

13) Summary and Purpose of Repealer: Effective July 1, 2012, Save Medicaid Access and Resources Together (SMART) Act mandates the elimination of the Illinois Cares Rx Program.

14) Information and questions regarding this adopted rulemaking shall be directed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Medical Assistance Programs
- 2) Code Citation: 89 Ill. Adm. Code 120
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
120.34	Repeal
120.80	Amendment
120.347	Amendment
120.379	Amendment
120.380	Amendment
120.381	Amendment
120.385	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: February 1, 2013, 2010; 37 Ill. Reg. 947
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: The following changes have been made:
  - In Section 120.80(a), add "Effective July 1, 2012,"
  - In Section 120.347(d)(2), added "Effective July 1, 2012,".
  - In Section 120.379(d)(1), added "Effective July 1, 2012,".
  - In Section 120.379(e)(1)(A), added "Effective July 1, 2012,".

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

In Section 120.379(j) and (k), added "Effective July 1, 2012,".

In Section 120.380(d)(2), added "Effective July 1, 2012,"

In Section 120.381(a)(1)(C), change "real property, including real property" to "homestead property transferred to a" and delete "claimed as homestead, held in"

In Section 120.381(a), added "Effective July 1, 2012,".

In Section 120.381(a)(3), after "including" add ",effective January 1, 2014,":

In Section 120.380(k)(1), delete "Effective July 1, 2012" reinstate the underlined text that was stricken originally and after the parenthesis add "through December 31, 2013".

In Section 120.385(c)(1), delete "A", and replace the stricken text with "Effective July 1, 2012, a".

In Section 120.385, added "Effective July 1, 2012,".

- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace an emergency rulemaking currently in effect? Yes, July 1, 2012; 36 Ill. Reg. 10253.
- 14) Are there any other proposed rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: These administrative rules are authorized pursuant to Public Act 97-689, the Save Medicaid Access and Resources Together (SMART) Act. The SMART Act terminates, as of July 1, 2012, eligibility for caretaker relatives in the Family Care Program who have income over 133% of the federal poverty level. The SMART Act also authorizes the tightening of the long term care asset testing policy for persons who seek to utilize institutional services.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

Springfield IL 62763-0002

217/782-1233

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 120

MEDICAL ASSISTANCE PROGRAMS

SUBPART A: GENERAL PROVISIONS

Section

120.1 Incorporation by Reference

SUBPART B: ASSISTANCE STANDARDS

Section

120.10 Eligibility for Medical Assistance

120.11 MANG(P) Eligibility

120.12 Healthy Start – Medicaid Presumptive Eligibility Program For Pregnant Women

120.14 Presumptive Eligibility for Children

120.20 MANG(AABD) Income Standard

120.30 MANG(C) Income Standard

120.31 MANG(P) Income Standard

120.32 FamilyCare Assist

120.34 FamilyCare Share and FamilyCare Premium Level 1 (Repealed)

120.40 Exceptions To Use Of MANG Income Standard (Repealed)

120.50 AMI Income Standard (Repealed)

SUBPART C: FINANCIAL ELIGIBILITY DETERMINATION

Section

120.60 Community Cases

120.61 Long Term Care

120.62 Department of Mental Health and Developmental Disabilities (DMHDD)  
Approved Home and Community Based Residential Settings Under 89 Ill. Adm.  
Code 140.643 (Repealed)

120.63 Department of Mental Health and Developmental Disabilities (DMHDD)  
Approved Home and Community Based Residential Settings (Repealed)

120.64 MANG(P) Cases

120.65 Department of Mental Health and Developmental Disabilities (DMHDD)  
Licensed Community – Integrated Living Arrangements (Repealed)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

## SUBPART D: MEDICARE PREMIUMS

Section	
120.70	Supplementary Medical Insurance Benefits (SMIB) Buy-In Program
120.72	Eligibility for Medicare Cost Sharing as a Qualified Medicare Beneficiary (QMB)
120.73	Eligibility for Payment of Medicare Part B Premiums for Specified Low-Income Medicare Beneficiaries (SLIBs) and Qualified Individuals-1 (QI-1)
120.74	Qualified Medicare Beneficiary (QMB) Income Standard
120.75	Specified Low-Income Medicare Beneficiaries (SLIBs) and Qualified Individuals-1 (QI-1) Income Standards
120.76	Hospital Insurance Benefits (HIB)

## SUBPART E: RECIPIENT RESTRICTION PROGRAM

Section	
120.80	Recipient Restriction Program

## SUBPART F: MIGRANT MEDICAL PROGRAM

Section	
120.90	Migrant Medical Program (Repealed)
120.91	Income Standards (Repealed)

## SUBPART G: AID TO THE MEDICALLY INDIGENT

Section	
120.200	Elimination Of Aid To The Medically Indigent
120.208	Client Cooperation (Repealed)
120.210	Citizenship (Repealed)
120.211	Residence (Repealed)
120.212	Age (Repealed)
120.215	Relationship (Repealed)
120.216	Living Arrangement (Repealed)
120.217	Supplemental Payments (Repealed)
120.218	Institutional Status (Repealed)
120.224	Foster Care Program (Repealed)
120.225	Social Security Numbers (Repealed)
120.230	Unearned Income (Repealed)
120.235	Exempt Unearned Income (Repealed)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

120.236	Education Benefits (Repealed)
120.240	Unearned Income In-Kind (Repealed)
120.245	Earmarked Income (Repealed)
120.250	Lump Sum Payments and Income Tax Refunds (Repealed)
120.255	Protected Income (Repealed)
120.260	Earned Income (Repealed)
120.261	Budgeting Earned Income (Repealed)
120.262	Exempt Earned Income (Repealed)
120.270	Recognized Employment Expenses (Repealed)
120.271	Income From Work/Study/Training Program (Repealed)
120.272	Earned Income From Self-Employment (Repealed)
120.273	Earned Income From Roomer and Boarder (Repealed)
120.275	Earned Income In-Kind (Repealed)
120.276	Payments from the Illinois Department of Children and Family Services (Repealed)
120.280	Assets (Repealed)
120.281	Exempt Assets (Repealed)
120.282	Asset Disregards (Repealed)
120.283	Deferral of Consideration of Assets (Repealed)
120.284	Spend-down of Assets (AMI) (Repealed)
120.285	Property Transfers (Repealed)
120.290	Persons Who May Be Included in the Assistance Unit (Repealed)
120.295	Payment Levels for AMI (Repealed)

## SUBPART H: MEDICAL ASSISTANCE – NO GRANT (MANG) ELIGIBILITY FACTORS

Section	
120.308	Client Cooperation
120.309	Caretaker Relative
120.310	Citizenship
120.311	Residence
120.312	Age
120.313	Blind
120.314	Disabled
120.315	Relationship
120.316	Living Arrangements
120.317	Supplemental Payments
120.318	Institutional Status
120.319	Assignment of Rights to Medical Support and Collection of Payment
120.320	Cooperation in Establishing Paternity and Obtaining Medical Support

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- 120.321 Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support
- 120.322 Proof of Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support
- 120.323 Suspension of Paternity Establishment and Obtaining Medical Support Upon Finding Good Cause
- 120.324 Health Insurance Premium Payment (HIPP) Program
- 120.325 Health Insurance Premium Payment (HIPP) Pilot Program
- 120.326 Foster Care Program
- 120.327 Social Security Numbers
- 120.328 Compliance with Employment and Work Activity Requirements (Suspended; Repealed)
- 120.329 Compliance with Non-Economic Eligibility Requirements of Article IV (Suspended; Repealed)
- 120.330 Unearned Income
- 120.332 Budgeting Unearned Income
- 120.335 Exempt Unearned Income
- 120.336 Education Benefits
- 120.338 Incentive Allowance
- 120.340 Unearned Income In-Kind
- 120.342 Child Support and Spousal Maintenance Payments
- 120.345 Earmarked Income
- 120.346 Medicaid Qualifying Trusts
- 120.347 Treatment of Trusts and Annuities
- 120.350 Lump Sum Payments and Income Tax Refunds
- 120.355 Protected Income
- 120.360 Earned Income
- 120.361 Budgeting Earned Income
- 120.362 Exempt Earned Income
- 120.363 Earned Income Disregard – MANG(C)
- 120.364 Earned Income Exemption
- 120.366 Exclusion From Earned Income Exemption
- 120.370 Recognized Employment Expenses
- 120.371 Income From Work/Study/Training Programs
- 120.372 Earned Income From Self-Employment
- 120.373 Earned Income From Roomer and Boarder
- 120.375 Earned Income In-Kind
- 120.376 Payments from the Illinois Department of Children and Family Services
- 120.379 Provisions for the Prevention of Spousal Impoverishment
- 120.380 Resources

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- 120.381 Exempt Resources  
120.382 Resource Disregard  
120.383 Deferral of Consideration of Assets  
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## SUBPART I: SPECIAL PROGRAMS

## Section

- 120.500 Health Benefits for Persons with Breast or Cervical Cancer  
120.510 Health Benefits for Workers with Disabilities  
120.520 SeniorCare (Repealed)  
120.530 Home and Community Based Services Waivers for Medically Fragile, Technology Dependent, Disabled Persons Under Age 21  
120.540 Illinois Healthy Women Program  
120.550 Asylum Applicants and Torture Victims
- 120.TABLE A Value of a Life Estate and Remainder Interest  
120.TABLE B Life Expectancy (Repealed)

AUTHORITY: Implementing Articles III, IV, V and VI and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and 12-13] and implementing the federal Deficit Reduction Act of 2005.

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SOURCE: Filed effective December 30, 1977; peremptory amendment at 2 Ill. Reg. 17, p. 117, effective February 1, 1978; amended at 2 Ill. Reg. 31, p. 134, effective August 5, 1978; emergency amendment at 2 Ill. Reg. 37, p. 4, effective August 30, 1978, for a maximum of 150 days; peremptory amendment at 2 Ill. Reg. 46, p. 44, effective November 1, 1978; peremptory amendment at 2 Ill. Reg. 46, p. 56, effective November 1, 1978; emergency amendment at 3 Ill. Reg. 16, p. 41, effective April 9, 1979, for a maximum of 150 days; emergency amendment at 3 Ill. Reg. 28, p. 182, effective July 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 33, p. 415, effective August 18, 1979; amended at 3 Ill. Reg. 38, p. 243, effective September 21, 1979; peremptory amendment at 3 Ill. Reg. 38, p. 321, effective September 7, 1979; amended at 3 Ill. Reg. 40, p. 140, effective October 6, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 22, 1980; amended at 4 Ill. Reg. 10, p. 258, effective February 25, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; amended at 4 Ill. Reg. 27, p. 387, effective June 24, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 37, p. 800, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 27, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1134, effective January 26, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; amended at 5 Ill. Reg. 7104, effective June 23, 1981; amended at 5 Ill. Reg. 8041, effective July 27, 1981; amended at 5 Ill. Reg. 8052, effective July 24, 1981; peremptory amendment at 5 Ill. Reg. 8106, effective August 1, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10079, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10095, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10113, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10124, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10131, effective October 1, 1981; amended at 5 Ill. Reg. 10730, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 10760, effective October 1, 1981; amended at 5 Ill. Reg. 10767, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 11647, effective October 16, 1981; peremptory amendment at 6 Ill. Reg. 611, effective January 1, 1982; amended at 6 Ill. Reg. 1216, effective January 14, 1982; emergency amendment at 6 Ill. Reg. 2447, effective March 1, 1982, for a maximum of 150 days; peremptory amendment at 6 Ill. Reg. 2452, effective February 11, 1982; peremptory amendment at 6 Ill. Reg. 6475, effective May 18, 1982; peremptory amendment at 6 Ill. Reg. 6912, effective May 20, 1982; emergency amendment at 6 Ill. Reg. 7299, effective June 2, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 8115, effective July 1, 1982; amended at 6 Ill. Reg. 8142, effective July 1, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10970, effective August 26, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12293, effective October 1, 1982; amended at 6 Ill. Reg. 12318, effective

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October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 394, effective January 1, 1983; codified at 7 Ill. Reg. 6082; amended at 7 Ill. Reg. 8256, effective July 1, 1983; amended at 7 Ill. Reg. 8264, effective July 5, 1983; amended (by adding Section being codified with no substantive change) at 7 Ill. Reg. 14747; amended (by adding Sections being codified with no substantive change) at 7 Ill. Reg. 16108; amended at 8 Ill. Reg. 5253, effective April 9, 1984; amended at 8 Ill. Reg. 6770, effective April 27, 1984; amended at 8 Ill. Reg. 13328, effective July 16, 1984; amended (by adding Sections being codified with no substantive change) at 8 Ill. Reg. 17897; amended at 8 Ill. Reg. 18903, effective September 26, 1984; peremptory amendment at 8 Ill. Reg. 20706, effective October 3, 1984; amended at 8 Ill. Reg. 25053, effective December 12, 1984; emergency amendment at 9 Ill. Reg. 830, effective January 3, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 4515, effective March 25, 1985; amended at 9 Ill. Reg. 5346, effective April 11, 1985; amended at 9 Ill. Reg. 7153, effective May 6, 1985; amended at 9 Ill. Reg. 11346, effective July 8, 1985; amended at 9 Ill. Reg. 12298, effective July 25, 1985; amended at 9 Ill. Reg. 12823, effective August 9, 1985; amended at 9 Ill. Reg. 15903, effective October 4, 1985; amended at 9 Ill. Reg. 16300, effective October 10, 1985; amended at 9 Ill. Reg. 16906, effective October 18, 1985; amended at 10 Ill. Reg. 1192, effective January 10, 1986; amended at 10 Ill. Reg. 3033, effective January 23, 1986; amended at 10 Ill. Reg. 4907, effective March 7, 1986; amended at 10 Ill. Reg. 6966, effective April 16, 1986; amended at 10 Ill. Reg. 10688, effective June 3, 1986; amended at 10 Ill. Reg. 12672, effective July 14, 1986; amended at 10 Ill. Reg. 15649, effective September 19, 1986; amended at 11 Ill. Reg. 3992, effective February 23, 1987; amended at 11 Ill. Reg. 7652, effective April 15, 1987; amended at 11 Ill. Reg. 8735, effective April 20, 1987; emergency amendment at 11 Ill. Reg. 12458, effective July 10, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 14034, effective August 14, 1987; amended at 11 Ill. Reg. 14763, effective August 26, 1987; amended at 11 Ill. Reg. 20142, effective January 1, 1988; amended at 11 Ill. Reg. 20898, effective December 14, 1987; amended at 12 Ill. Reg. 904, effective January 1, 1988; amended at 12 Ill. Reg. 3516, effective January 22, 1988; amended at 12 Ill. Reg. 6234, effective March 22, 1988; amended at 12 Ill. Reg. 8672, effective May 13, 1988; amended at 12 Ill. Reg. 9132, effective May 20, 1988; amended at 12 Ill. Reg. 11483, effective June 30, 1988; emergency amendment at 12 Ill. Reg. 11632, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 11839, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12835, effective July 22, 1988; emergency amendment at 12 Ill. Reg. 13243, effective July 29, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 17867, effective October 30, 1988; amended at 12 Ill. Reg. 19704, effective November 15, 1988; amended at 12 Ill. Reg. 20188, effective November 23, 1988; amended at 13 Ill. Reg. 116, effective January 1, 1989; amended at 13 Ill. Reg. 2081, effective February 3, 1989; amended at 13 Ill. Reg. 3908, effective March 10, 1989; emergency amendment at 13 Ill. Reg. 11929, effective June 27, 1989, for a maximum of 150 days; emergency expired November 25, 1989; emergency amendment at 13 Ill. Reg. 12137, effective July 1, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 15404, effective October 6, 1989; emergency amendment at 13 Ill. Reg.

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16586, effective October 2, 1989, for a maximum of 150 days; emergency expired March 1, 1990; amended at 13 Ill. Reg. 17483, effective October 31, 1989; amended at 13 Ill. Reg. 17838, effective November 8, 1989; amended at 13 Ill. Reg. 18872, effective November 17, 1989; amended at 14 Ill. Reg. 760, effective January 1, 1990; emergency amendment at 14 Ill. Reg. 1494, effective January 2, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 4233, effective March 5, 1990; emergency amendment at 14 Ill. Reg. 5839, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 6372, effective April 16, 1990; amended at 14 Ill. Reg. 7637, effective May 10, 1990; amended at 14 Ill. Reg. 10396, effective June 20, 1990; amended at 14 Ill. Reg. 13227, effective August 6, 1990; amended at 14 Ill. Reg. 14814, effective September 3, 1990; amended at 14 Ill. Reg. 17004, effective September 30, 1990; emergency amendment at 15 Ill. Reg. 348, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 5302, effective April 1, 1991; amended at 15 Ill. Reg. 10101, effective June 24, 1991; amended at 15 Ill. Reg. 11973, effective August 12, 1991; amended at 15 Ill. Reg. 12747, effective August 16, 1991; amended at 15 Ill. Reg. 14105, effective September 11, 1991; amended at 15 Ill. Reg. 14240, effective September 23, 1991; amended at 16 Ill. Reg. 139, effective December 24, 1991; amended at 16 Ill. Reg. 1862, effective January 20, 1992; amended at 16 Ill. Reg. 10034, effective June 15, 1992; amended at 16 Ill. Reg. 11582, effective July 15, 1992; amended at 16 Ill. Reg. 17290, effective November 3, 1992; amended at 17 Ill. Reg. 1102, effective January 15, 1993; amended at 17 Ill. Reg. 6827, effective April 21, 1993; amended at 17 Ill. Reg. 10402, effective June 28, 1993; amended at 18 Ill. Reg. 2051, effective January 21, 1994; amended at 18 Ill. Reg. 5934, effective April 1, 1994; amended at 18 Ill. Reg. 8718, effective June 1, 1994; amended at 18 Ill. Reg. 11231, effective July 1, 1994; amended at 19 Ill. Reg. 2905, effective February 27, 1995; emergency amendment at 19 Ill. Reg. 9280, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 11931, effective August 11, 1995; amended at 19 Ill. Reg. 15079, effective October 17, 1995; amended at 20 Ill. Reg. 5068, effective March 20, 1996; amended at 20 Ill. Reg. 15993, effective December 9, 1996; emergency amendment at 21 Ill. Reg. 692, effective January 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 7423, effective May 31, 1997; amended at 21 Ill. Reg. 7748, effective June 9, 1997; amended at 21 Ill. Reg. 11555, effective August 1, 1997; amended at 21 Ill. Reg. 13638, effective October 1, 1997; emergency amendment at 22 Ill. Reg. 1576, effective January 5, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 7003, effective April 1, 1998; amended at 22 Ill. Reg. 8503, effective May 1, 1998; amended at 22 Ill. Reg. 16291, effective August 28, 1998; emergency amendment at 22 Ill. Reg. 16640, effective September 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19875, effective October 30, 1998; amended at 23 Ill. Reg. 2381, effective January 22, 1999; amended at 23 Ill. Reg. 11301, effective August 27, 1999; amended at 24 Ill. Reg. 7361, effective May 1, 2000; emergency amendment at 24 Ill. Reg. 10425, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15075, effective October 1, 2000; amended at 24 Ill. Reg. 18309, effective December 1, 2000; amended at 25 Ill. Reg. 8783, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 10533, effective August 1, 2001, for a maximum of 150 days;

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amended at 25 Ill. Reg. 16098, effective December 1, 2001; amended at 26 Ill. Reg. 409, effective December 28, 2001; emergency amendment at 26 Ill. Reg. 8583, effective June 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 9843, effective June 26, 2002; emergency amendment at 26 Ill. Reg. 11029, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 15051, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16288, effective October 25, 2002; amended at 27 Ill. Reg. 4708, effective February 25, 2003; emergency amendment at 27 Ill. Reg. 10793, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18609, effective November 26, 2003; amended at 28 Ill. Reg. 4701, effective March 3, 2004; amended at 28 Ill. Reg. 6139, effective April 1, 2004; emergency amendment at 28 Ill. Reg. 6610, effective April 19, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 7152, effective May 3, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11149, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12921, effective September 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13621, effective September 28, 2004; amended at 28 Ill. Reg. 13760, effective October 1, 2004; amended at 28 Ill. Reg. 14541, effective November 1, 2004; amended at 29 Ill. Reg. 820, effective January 1, 2005; amended at 29 Ill. Reg. 10195, effective June 30, 2005; amended at 29 Ill. Reg. 14939, effective September 30, 2005; emergency amendment at 30 Ill. Reg. 521, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 10314, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 15029, effective September 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 2629, effective January 28, 2007; emergency amendment at 31 Ill. Reg. 7323, effective May 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11667, effective August 1, 2007; amended at 31 Ill. Reg. 12756, effective August 27, 2007; emergency amendment at 31 Ill. Reg. 15854, effective November 7, 2007, for a maximum of 150 days; emergency rule suspended at 31 Ill. Reg. 16060, effective November 13, 2007; emergency rule repealed, effective May 10, 2008; peremptory amendment at 32 Ill. Reg. 7212, effective April 21, 2008; peremptory amendment suspended at 32 Ill. Reg. 8450, effective May 20, 2008; peremptory amendment repealed under Section 5-125 of the Illinois Administrative Procedure Act, effective November 16, 2008; amended at 32 Ill. Reg. 17428, effective November 1, 2008; peremptory amendment at 32 Ill. Reg. 18889, effective November 18, 2008; peremptory amendment suspended at 32 Ill. Reg. 18906, effective November 19, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 33 Ill. Reg. 6551, effective April 28, 2009; peremptory amendment repealed by emergency rulemaking at 33 Ill. Reg. 6712, effective April 28, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 1681, effective February 1, 2009; amended at 33 Ill. Reg. 2289, effective March 1, 2009; emergency amendment at 33 Ill. Reg. 5802, effective April 2, 2009, for a maximum of 150 days; emergency expired August 29, 2009; emergency amendment at 33 Ill. Reg. 10785, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 12703, effective September 7, 2009; amended at 33 Ill. Reg. 15707, effective November 2, 2009; amended at 33 Ill. Reg. 17070, effective December 2, 2009; amended at 34 Ill. Reg. 889, effective December 30, 2009; emergency rulemaking at 34 Ill. Reg. 13538, effective September 1, 2010, for a

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maximum of 150 days; amended at 35 Ill. Reg. 379, effective December 27, 2010; amended at 35 Ill. Reg. 979, effective January 1, 2011; amended at 35 Ill. Reg. 18645, effective January 1, 2012; amended at 36 Ill. Reg. 4133, effective March 1, 2012; amended at 36 Ill. Reg. 9095, effective June 11, 2012; emergency amendment at 36 Ill. Reg. 10253, effective July 1, 2012 through June 30, 2013; amended at 36 Ill. Reg. 17044, effective November 26, 2012; emergency amendment at 36 Ill. Reg. 17549, effective December 3, 2012 through June 30, 2013; amended at 37 Ill. Reg. 10208, effective June 27, 2013.

## SUBPART B: ASSISTANCE STANDARDS

**Section 120.34 FamilyCare Share and FamilyCare Premium Level 1 (Repealed)**

- a) ~~A caretaker relative (see Section 120.390) who is 19 years of age or older qualifies for medical assistance when countable income is at or below the appropriate income standard.~~
- b) ~~The caretaker relative may not be otherwise eligible for medical assistance, including Section 120.32.~~
- e) ~~The appropriate income standard is 185 percent of the Federal Poverty Income Level Guidelines, as published annually in the Federal Register, for the appropriate family size. If income is greater than this amount, the Department shall compare it to the MANG(C) Income Standard in Section 120.30 to determine the spenddown amount.~~
- d) ~~Caretaker relatives will be enrolled into either FamilyCare Share or FamilyCare Premium Level 1 as follows:~~
  - 1) ~~If monthly countable income is above 133 percent and at or below 150 percent of the Federal Poverty Level (FPL) for the number of persons in the family, coverage under FamilyCare Share shall be effective as established in 89 Ill. Adm. Code 110.34.~~
  - 2) ~~If monthly countable income is above 150 percent and at or below 185 percent of the FPL for the number of persons in the family, an eligible caretaker relative shall be enrolled prospectively in FamilyCare Premium Level I and premiums shall be payable as established in subsection (f)(1) of this Section. Coverage for months prior to the first prospective month of coverage as established in 89 Ill. Adm. Code 110.34 shall be dependent~~

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- ~~on payment of premiums for those months as set forth in subsection (f)(2) of this Section.~~
- ~~3) The first month of prospective eligibility for caretaker relatives whose eligibility for FamilyCare Premium Level 1 is determined by the 15<sup>th</sup> of the month will be the following month. The first month of prospective eligibility for caretaker relatives whose eligibility for FamilyCare Premium Level 1 is determined after the 15<sup>th</sup> day of the month will be the second month following that determination.~~
- e) ~~Caretaker relatives enrolled in FamilyCare Premium Level 1 must pay monthly premiums based upon based upon the total number of adults in the family enrolled in FamilyCare Premium Level 1 and children in the family enrolled under 89 Ill. Adm. Code 125.240(c)(2).~~
- ~~1) The premium amounts are \$15 for one person, \$25 for two persons, \$30 for three persons, \$35 for four persons, and \$40 for five or more persons.~~
- ~~2) Premiums are billed by and payable to the Department, or its authorized agent, on a monthly basis.~~
- ~~3) The premium due date will be the last day of the calendar month preceding the month of coverage.~~
- ~~4) No premiums will be charged to families with an enrolled person who is an American Indian or Alaska Native.~~
- f) ~~FamilyCare Premium Level 1 premiums shall be due as follows:~~
- ~~1) Premiums owed for the first prospective month of coverage and each subsequent month shall be due by the last day of the month preceding the month of coverage. Participants shall have a minimum grace period through the end of the month of coverage to pay the premium. Failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.~~
- ~~2) Coverage for the months of eligibility prior to the first prospective month of eligibility will not be authorized until the premium payment is received.~~
- ~~3) Partial premium payments will not be refunded.~~

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- ~~g) An eligible caretaker relative becomes ineligible due to:~~
- ~~1) For those with countable income above 150 percent FPL, not paying the required premiums.~~
  - ~~2) For those with countable income above 150 percent FPL, not repaying a rebate overpayment under 89 Ill. Adm. Code 125 to the Department, according to terms established by the Department, which may include recoupment out of future rebate payments or a payment plan.~~
- ~~h) Following termination of coverage under FamilyCare, the following action is required before the caretaker relative can be re-enrolled:~~
- ~~1) For caretaker relatives with countable income above 150 percent of the FPL, there must be full payment of premiums under Section 120.510 of FamilyCare, AllKids Premium Levels 1-8 under 89 Ill. Adm. Code 123 or 89 Ill. Adm. Code 125, Health Benefits for Workers with Disabilities under Section 120.510 of this Part, or Veterans Care under 89 Ill. Adm. Code 128, for periods in which a premium was owed, including premiums owed when the caretaker relative was, for purposes of this Part, a member of another family;~~
  - ~~2) For persons with countable income above 150 percent of the FPL, any overpayment of rebates must be repaid to the Department. A rebate overpayment shall be considered repaid if the Department can recoup the overpayment out of future rebate payments; and~~
  - ~~3) The first month's premium must be paid if the caretaker relative is eligible for FamilyCare Premium Level 1 and there was an unpaid premium on the date the caretaker relative's previous eligibility was cancelled.~~
- ~~i) An application will be denied if any of the eligible caretaker relatives with income above 150 percent of the FPL in the family was responsible as a caretaker relative, or eligible as a caretaker relative during a period for which a premium under FamilyCare was due to the Department, and the premium remains unpaid at the time of application. That application shall be denied, regardless of whether the caretaker relative for whom the premium remains unpaid is included in the application.~~

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(Source: Repealed at 37 Ill. Reg. 10208, effective June 27, 2013)

## SUBPART E: RECIPIENT RESTRICTION PROGRAM

**Section 120.80 Recipient Restriction Program**

- a) Effective July 1, 2012, theThe Recipient Restriction Program (RRP) shall identify recipients who unnecessarily utilize medical services. When the Department determines, on the basis of statistical norms and the medical judgment of individual practitioners and/or pharmacists, or other providers, that a Medicaid recipient has received medical services that are not medically necessary based on the recipient's diagnoses and/or medical condition or conditions or in such a manner as to constitute an abuse of medical privileges or Program services, the decision to restrict a recipient to one or more primary provider types will be made. For purposes of this Section, "primary provider type" means an individual practitioner in any of the following licensed or certified health care professions: physician, optometrist, chiropractor, pharmacist, dentist, any advanced practice nurse, registered nurse, licensed practical nurse, genetic counselor, physical therapist, podiatrist, speech therapist, psychologist, audiologist, occupational therapist or physician assistant. A primary provider type also means a business entity, partnership or group practice comprised of or employing any of the individual practitioners listed in this subsection (a). A primary provider type can also mean any of the following: hospice provider, home health agency, transportation provider, community health agency, imaging service, optical company, optician, optometrist, independent laboratory, clinical social worker, Department of Human Services-Division of Alcohol and Substance Abuse provider, durable medical equipment provider, provider of medical equipment and supplies, case management provider, behavioral health professional provider, a provider of services authorized under a federal Medicaid waiver, or any other provider of medical assistance programs authorized under the Illinois Public Aid Code or its administrative rules. a primary care provider, primary care pharmacy, primary care dentist, primary care podiatrist, or primary durable medical equipment provider. The RRP applies to all medical assistance programs administered by the Department, with the exception of full risk Managed Care Organizations (MCO).
- b) Primary and Secondary Sources of Recipient Identification
- 1) The primary source of recipient identification shall be the Surveillance and Utilization Review Subsystem (SURS) of the Medicaid Management

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Information System (MMIS). On an ongoing basis, SURS analyzes the Medicaid population, determines medical usage per recipient and will identify recipients with usages in excess of the established norm of recipients in the same category of assistance and like demographic areas.

- 2) Secondary sources of identification shall be incoming referrals, such as referrals from medical providers, law enforcement officials or members of the general public. All referrals shall be reviewed and analyzed. Recipients found to have loaned or altered their medical cards for the purpose of obtaining medical benefits for which they or other persons are not legitimately entitled; falsely represented medical coverage; found in possession of blank or forged prescription pads; or who knowingly assisted providers in rendering excessive services or defrauding the Medical Assistance Program shall be restricted.
- c) Once a recipient is identified, medical usage based on diagnoses and/or medical condition for the preceding 24 months shall be reviewed. Medical Assistance Consultants and licensed individual practitioners and/or pharmacists will determine if the recipient should be restricted due to the medical services received being not medically necessary. The Department shall initially designate, without regard to choice, a primary provider type or types (type). The Department's designation shall remain in effect for the entire period of the restriction unless the recipient changes this designation pursuant to subsection (f) of this Section. Each recipient to be restricted will be notified in writing. This notice will also contain a statement relating to the medical necessity of services consistent with the findings of the professional consultants; a statement advising the recipient of his or her right to appeal; and a toll-free number to call for information.
- d) Department Designated Primary Provider Type
  - 1) The Department will select the applicable primary provider type in reasonable geographical proximity to the recipient's home to serve as the recipient's primary provider type.
  - 2) The primary provider type must be a properly enrolled Medicaid provider in good standing with the Department, properly licensed and credentialed and willing to serve as a primary provider type.
  - 3) If a primary care provider is selected as the primary provider type, he or she shall be a medical doctor or doctor of osteopathy licensed to practice

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medicine in all of its branches or a clinic enrolled to provide primary care.

- e) Types of Services Provided or Authorized
- 1) Once restricted, the Recipient Eligibility Verification (REV) system shall display information regarding the primary provider type. REV will also display information that emergency services will not be restricted.
  - 2) If restricted to a primary care provider, the primary care provider must provide or authorize the following non-emergency ambulatory care services for the restricted recipient before the Department will render payment for the services:
    - A) Clinic
    - B) Laboratory
    - C) Outpatient Hospital
    - D) Pharmacy
    - E) Physician
  - 3) If restricted to a primary care pharmacy, the primary care pharmacy must supply all prescriptions for the restricted recipient. Authorization to obtain non-emergency prescriptions from any other source will only be approved when a specific item is not part of the primary care pharmacy's inventory and cannot be acquired through the primary care pharmacy.
  - 4) If restricted to a primary care dentist, the primary care dentist must provide or authorize all dental services for the restricted recipient before the Department will render payment for the dental services.
  - 5) If restricted to a primary care podiatrist, the primary care podiatrist must provide or authorize all podiatric services for the restricted recipient before the Department will render payment for the podiatric services.
  - 6) If restricted to a primary durable medical equipment provider, the primary durable medical equipment provider must supply all medical supplies for the restricted recipient. Authorization to obtain medical supplies from any

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other source will only be approved when a specific item is not part of the primary durable medical equipment provider's inventory and cannot be acquired through the primary durable medical equipment provider.

- 7) Other covered services may be provided by a qualified provider in the Department's Medical Program.
- f) Changing the Designated Primary Provider Type
- 1) The recipient may change the Department's initial designation of a primary provider type once without cause. The request for change must be submitted to the Department in writing. The Department, by notice, shall inform the recipient how to request a change in primary provider type.
  - 2) The recipient may change his or her designated provider for cause if one of the following circumstances is verified:
    - A) Change of recipient's residence from the geographical area of the primary provider type;
    - B) Change in the recipient's medical condition that the primary provider type is unable to treat or refer to another provider;
    - C) Death of the primary provider type;
    - D) Disenrollment of the primary provider type from the Medical Assistance Program; and
    - E) Notice from the primary provider type that he, she or it will no longer serve as the primary provider type.
  - 3) The Department will notify the recipient in writing if the primary provider type has disenrolled as a provider of Medicaid services or if the provider notifies the Department of his, her or its unwillingness to continue to serve as the recipient's primary provider type.
  - 4) Changes in designated primary provider type shall be processed effective with the earliest possible date reflected on the eligibility file.

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- 5) For the designated primary provider type, the Department will determine if the requested change meets the criteria in subsection (d) of this Section.
- g) Length of Restriction
- 1) Once recipients are restricted they remain in restriction for a minimum of four full quarters. If restricted recipients transfer to a different assistance unit, the restriction will be processed to follow the recipient. If a restricted recipient becomes inactive and is subsequently reactivated, the restriction will be reactivated until such time as four full quarters have elapsed.
  - 2) Reevaluation of the Recipient's Medical Usage
    - A) When a recipient has had his or her medical card restricted for four full quarters, the Department shall reevaluate the recipient's medical usage to determine whether the recipient continues to receive medical services that are not medically necessary. The Department shall evaluate each case not later than eighteen months after the effective date of restriction. If the recipient is still receiving medical services that are not medically necessary, the restriction shall be continued for an additional period of eight full quarters. This additional period of eight full quarters shall begin with the first month immediately following the end of the first four full quarter restriction period. If the recipient no longer is receiving medical services that are not medically necessary, the restriction shall be discontinued. A "quarter", for purposes of this Section, shall be defined as one of the following three-month periods of time: January-March, April-June, July-September or October-December.
    - B) If necessary to determine if medical services that are not medically necessary are still being received, the Department shall obtain a complete copy of the recipient's medical record from the primary provider type. The medical record will be reviewed by the Medical Assistant Consultant with a final determination by a licensed individual practitioner to determine if the medical services received were medically necessary.
    - C) If the decision is to release the recipient from restriction, such release will be processed effective with the earliest possible date

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reflected on the eligibility file.

- D) If the services are determined to be medically unnecessary, the recipient will be notified in writing of the continued restriction. The Department may designate a different individual provider type. The criteria in subsection (d) of this Section shall apply. This notice will also contain a statement relating to the medical necessity of services consistent with the findings of the professional consultants; a statement advising the recipient of his or her right to appeal; and a toll-free number to call for information.
- 3) If the restriction is continued, a review will be conducted in accordance with subsection (g)(2) of this Section, subsequent to the additional eight quarter period.
- 4) A recipient who has been restricted under this Section, is released and then is restricted under this Section a subsequent time, shall be restricted for a period of eight full quarters. Subsequent to this eight quarter period, a review will be conducted in accordance with subsection (g)(2) of this Section.
- h) Recipients have the right to appeal inclusion in the program. (See 89 Ill. Adm. Code 102.80 through 102.84.)
- i) Any recipient in the RRP who subsequently enrolls in a full risk MCO will be released from the RRP.

(Source: Amended at 37 Ill. Reg. 10208, effective June 27, 2013)

## SUBPART H: MEDICAL ASSISTANCE – NO GRANT (MANG) ELIGIBILITY FACTORS

**Section 120.347 Treatment of Trusts and Annuities**

- a) This Section applies to trusts established on or after August 11, 1993.
- b) A trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed or administered by the trustee or trustees for the benefit of the grantor or designated beneficiaries. A trust also includes any legal instrument or device that is similar to a trust, including an

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annuity.

- c) A person shall be considered to have established a trust if resources of the person were used to form all or part of the principal of the trust and the trust is established (other than by will) by any of the following:
- 1) the person;
  - 2) the person's spouse; or
  - 3) any other person, including a court or administrative body, with legal authority to act on behalf of or at the direction of the person or the person's spouse.
- d) This Section does not apply to the following trusts:
- 1) an irrevocable trust containing the resources of a person who is determined disabled (as provided in Section 120.314) and under age 65 that is established by a parent, grandparent, legal guardian or court for the sole benefit (as defined in Section 120.388(m)(2)) of the person, if language contained in the trust stipulates that any amount remaining in the trust (up to the amount expended by the Department on medical assistance) shall be paid to the Department upon the death of the person. This exclusion continues after the person reaches age 65 as long as the person continues to be disabled but any additions made by the person to the trust after age 65 will be treated as a transfer of assets under Sections 120.387 and 120.388. If the trust contains proceeds from a personal injury settlement, any Department charge (as described at 89 Ill. Adm. Code 102.260) must be satisfied in order for the trust to be excluded under this subsection; or
  - 2) Effective July 1, 2012, an irrevocable trust containing the resources of a person who is determined disabled (as provided in Section 120.314) that is established and managed by a non-profit association that pools funds but maintains a separate account for each beneficiary that is established by the disabled person, a parent, grandparent, legal guardian or court for the sole benefit of the disabled person, if language contained in the trust stipulates that any amount remaining in the trust (up to the amount expended by the Department on medical assistance) that is not retained by the trust for reasonable administrative costs related to wrapping up the affairs of the

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subaccount shall be paid to the Department upon the death of the person. After a person reaches age 65, any funding by or on behalf of the person to the trust shall be treated as a transfer of assets for less than fair market value unless the person is a ward of a county public guardian or the State guardian pursuant to Section 13-5 of the Probate Act of 1975 [755 ILCS 5] or Section 30 of the Guardianship and Advocacy Act [20 ILCS 3955] and lives in the community or the person is a ward of a county public guardian or the State guardian pursuant to Section 13-5 of the Probate Act of 1975 or Section 30 of the Guardianship and Advocacy Act and a court has found that any expenditures from the trust will maintain or enhance the person's quality of life. This exclusion continues after the person reaches age 65 as long as the person continues to meet the definition of disabled (to the extent permitted under federal law). Any funding of a subaccount in a pooled trust by a person over age 64 will be treated as a transfer for fair market value under Section 120.388 so long as the person meets the definition of disabled. If the trust contains proceeds from a personal injury settlement, any Department charge (as described at 89 Ill. Adm. Code 102.260) must be satisfied in order for the trust to be excluded under this subsection (d).

- e) Subsections (f) and (g) of this Section apply to the portion of the trust attributable to the person and without regard to:
- 1) the purpose for establishment of the trust;
  - 2) whether the trustee has or exercises any discretion under the trust; or
  - 3) whether there are any restrictions on distributions or use of distributions from the trust.
- f) For revocable trusts, the Department shall:
- 1) treat the principal as an available resource;
  - 2) treat as income payments from the trust that are made to or for the benefit of the person; and
  - 3) treat any other payments from the trust as transfers of assets by the person (subject to the provisions of, and depending on the date of the payment, Section 120.387 or 120.388).

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- g) For irrevocable trusts, the Department shall:
- 1) treat as an available resource the amount of the trust from which payment to or for the benefit of the person could be made;
  - 2) treat as income payments from the trust that are made to or for the benefit of the person;
  - 3) treat any other payments from the trust as transfers of assets by the person (subject to the provisions of Section 120.387 or 120.388, as applicable); and
  - 4) treat as a transfer of assets by the person the amount of the trust from which no payment could be made to the person under any circumstances (subject to the provisions of Section 120.387 or 120.388, as applicable). The date of the transfer is the date the trust was established or, if later, the date that payment to the person was foreclosed. The amount of the trust is determined by including any payments made from the trust after the date that payment to the person was foreclosed.
- h) Trust Income. For married couples, income from trusts shall be attributed to each spouse as provided in the trust, unless:
- 1) payment of income is made solely to one spouse, in which case the income shall be attributed to that spouse;
  - 2) payment of income is made to both spouses, in which case one-half of the income shall be attributed to each spouse; or
  - 3) payment of income is made to either spouse, or both, and to another person or persons, in which case the income shall be attributed to each spouse in proportion to the spouse's interest, or, if payment is made to both spouses and no such interest is specified, one-half of the joint interest shall be attributed to each spouse.
- i) Annuities are treated similar to trusts.
- 1) Revocable and assignable annuities are considered available resources.

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- 2) Any portion of an annuity from which payment to or for the benefit of the person or the person's spouse could be made is an available resource. An annuity that may be surrendered to its issuing entity for a refund or payment of a specified amount or provides a lump-sum settlement option is an available resource valued at the amount of any such refund, surrender or settlement.
  - 3) Income received from an annuity by an institutionalized person is considered non-exempt income. Income received by the community spouse of an institutionalized person is treated as available to the community spouse for the purpose of determining the community spouse income allowance under Section 120.379(e).
  - 4) An annuity that fails to name the State of Illinois as a remainder beneficiary as required under Section 120.385(b) shall result in denial or termination of eligibility for long term care services.
- j) The principal of a trust fund established under the Self Sufficiency Trust Fund Program (see 20 ILCS 1705/21.1) is an exempt resource.

(Source: Amended at 37 Ill. Reg. 10208, effective June 27, 2013)

**Section 120.379 Provisions for the Prevention of Spousal Impoverishment**

- a) The provisions for the prevention of spousal impoverishment apply only to an institutionalized person (as defined in Section 120.388(c)) whose spouse resides in the community. For purposes of this Section, those persons shall be referred to as the institutionalized spouse and the community spouse.
- b) Income. In determining the financial eligibility of an institutionalized spouse, only non-exempt income attributed to the institutionalized spouse shall be considered available. The following rebuttable presumptions shall apply in determining the income attributed to each spouse:
  - 1) if payment of income is made solely in the name of one spouse, the income will be considered available only to that spouse;
  - 2) if payment of income is made in the names of both spouses, one-half of the income shall be considered available to each spouse;

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- 3) if payment of income is made in the names of either spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made to both spouses and no other interest is specified, one-half of the joint interest shall be considered available to each spouse);
  - 4) if payment of income is made from a trust, the income shall be considered available to each spouse as provided under Section 120.347(h); and
  - 5) if there is no trust or instrument establishing ownership, one-half of the income shall be considered available to the institutionalized spouse and one-half to the community spouse.
- c) Resources. In determining the financial eligibility of an institutionalized spouse, the following shall apply:
- 1) At the beginning of a continuous period of institutionalization, the total value of resources owned by either or both spouses shall be computed.
  - 2) Assessment. Upon the request of an institutionalized spouse, community spouse, or a representative of either, at the beginning of a continuous period of institutionalization, the Department shall conduct an assessment of the couple's resources for the purpose of determining the combined amount of nonexempt resources in which either spouse has an ownership interest. The person requesting the assessment shall be responsible for providing documentation and verification necessary for the Department to complete the assessment.
  - 3) For purposes of this subsection (c), a continuous period of institutionalization is defined as at least 30 days of continuous institutional care. An initial assessment remains effective during that period if:
    - A) a resident of a long term care facility is discharged for a period of less than 30 days and then reenters the facility;
    - B) a resident of a long term care facility enters a hospital and then returns to the facility from the hospital;
    - C) a person discontinues receiving home and community-based services for a period of less than 30 days; or

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- D) a person discontinues receiving home and community-based services due to hospitalization and then is discharged and begins to receive home and community-based services.
- 4) At the time of an institutionalized spouse's application for medical assistance, all nonexempt resources held by either the institutionalized person, the community spouse, or both shall be considered available to the institutionalized spouse. From this amount may be deducted and transferred to the community spouse the Community Spouse Resource Allowance (CSRA), as provided under subsection (d) of this Section. The remaining amount shall be the total amount of resources considered available to the institutionalized spouse.
- d) Transfer of Resources to the Community Spouse. From the amount of nonexempt resources considered available to the institutionalized spouse, as described in subsection (c)(4) of this Section, a transfer of resources is allowed by the institutionalized spouse to the community spouse or to another individual for the sole benefit (as defined in Section 120.388(m)(2)(B)) of the community spouse in an amount that does not exceed the CSRA. The CSRA is the difference between the amount of resources otherwise available to the community spouse and the greatest of:
- 1) Effective July 1, 2012, the greater of the minimum amount permitted under section 1924(f)(2) of the Social Security Act (42 USC 1396r-5(f)(2)) reestablished annually by the US Department of Health and Human Services (DHHS) (as of January 1, 2011, \$109,560);
  - 2) the amount established through a fair hearing under subsection (f)(3) of this Section; or
  - 3) the amount transferred under a court order against an institutionalized spouse for the support of the community spouse.
- e) Deductions are allowed from an institutionalized spouse's post-eligibility income (pursuant to Section 120.61(d) and (e)) for a community spouse income allowance and a family allowance. The deductions are determined as follows:
- 1) Community Spouse Maintenance Allowance.

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- A) ~~Effective July 1, 2012, the~~The amount of monthly income that may be deducted from the institutionalized spouse's post-eligibility income for the benefit of the community spouse is equal to the minimum monthly maintenance needs allowance (MMMNA) less the amount of monthly income otherwise available to the community spouse (as determined under subsection (b) of this Section. The amount established as the MMMNA is the greater of the minimum amount permitted under section 1924(d)(3) of the Social Security Act (42 USC 1396r-5(d)(3)) or (as of January 1, 2011, \$2,739 per month) ~~shall be provided for calendar years after 2011 by DHHS.~~
- B) The deduction is allowed only to the extent the income of the person is in fact contributed to the community spouse. However, the deduction for the community spouse income allowance shall not be less than the amount ordered by a court for support of the community spouse or the amount determined as the result of a fair hearing provided for under subsection (f) of this Section.
- C) For purposes of this Section, all income of the institutionalized spouse that can be made available to the community spouse shall be made available before resources may be transferred in excess of the CSRA specified under subsection (d)(1) of this Section that will generate income to make up the difference between the MMMNA and the amount of income available to the community spouse.
- 2) Family Allowance. The amount of monthly income that may be deducted from the institutionalized spouse's post-eligibility income for the benefit of each family member is equal to one-third of the difference between the family maintenance needs standard (150% of the annual Federal Poverty Level for two persons) and any nonexempt income of the family member. Family members only include dependent children under age 21, dependent adult children, dependent parents or dependent siblings of either spouse who reside with the community spouse.
- 3) A deduction is also allowed from the institutionalized spouse's post-eligibility income for dependent children under age 21 who do not reside with the community spouse pursuant to Section 120.61(e)(5).
- 4) The term "dependent" has the meaning ascribed to a "qualified" person under 26 USC 152.

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- f) Fair Hearings. Either the institutionalized spouse or the community spouse may request a hearing (as described in 89 Ill. Adm. Code 104.1) under this Section for the following reasons:
- 1) either spouse is dissatisfied with a determination of:
    - A) the community spouse income allowance under subsection (e)(1) of this Section;
    - B) the amount of the monthly income treated as otherwise available to the community spouse (as applied under subsection (e)(1) of this Section);
    - C) the attribution of resources under subsection (c)(4) of this Section; or
    - D) the determination of the CSRA under subsection (d) of this Section.
  - 2) Either spouse may request an increase in the MMMNA under subsection (e)(1). If either spouse establishes that, due to exceptional circumstances resulting in significant financial duress, the community spouse needs income above the level provided by the MMMNA, an amount adequate to provide that additional income shall be substituted. For purposes of this subsection (f)(2), significant financial distress means expenses that the community spouse incurs in excess of the income standard, including:
    - A) recurring or extraordinary medical expenses of the community spouse that are not covered by any third party resource, including insurance or the Medical Assistance Program;
    - B) amounts necessary to preserve, maintain or make major repairs to homestead property; or
    - C) amounts necessary to preserve an income producing resource, subject to the limitations on that property under Section 120.381(a)(3) and as long as the expense is reasonable in relation to the income produced by the resource.

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- 3) Either spouse may request that an alternative CSRA be substituted for the standard CSRA calculated under subsection (d) of this Section if it can be established that the standard CSRA (in relation to the amount of income it generates) is inadequate to raise the community spouse's income to the MMMNA.
- A) Before a substitute CSRA may be allocated under this subsection (f)(3), the amount of income attributed to the institutionalized spouse that may be transferred to the community spouse under subsection (e) of this Section shall first be considered available to raise the community spouse's income to the MMMNA.
- B) If the sum of income otherwise available to the community spouse and income that may be transferred from the institutionalized spouse is insufficient to raise the community spouse's income to the MMMNA, then a substitute CSRA may be allowed. The amount the substitute CSRA may exceed the CSRA provided for under subsection (d) of this Section is limited to the amount of resources necessary to generate income to raise the community spouse's total income to the MMMNA.
- C) In determining the amount of income that a substitute CSRA under this subsection (f)(3) may generate, the Department will use, for purposes of comparison, the cost to purchase an actuarially sound single premium life annuity producing monthly payments that, when added to the community spouse's total income, will be sufficient to raise the community spouse's income to, but not more than, the MMMNA. If resources are insufficient to purchase an annuity that will raise the community spouse's income to the MMMNA, the Department will measure the amount of an allowable increase in the CSRA by the cost to purchase an actuarially sound single premium life annuity producing monthly payments using available resources.
- D) It is the requesting person's responsibility to provide the Department with an estimate from a reputable company of the cost to purchase the annuity described in subsection (f)(3)(C).
- E) The Department may compare the estimate with available information on the cost of other single premium life annuities.

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- F) In calculating the amount of the community spouse's income after approval of a substitute CSRA, the Department shall deem the amount of the monthly annuity payments as being available to the community spouse, although it will not require the actual purchase of an annuity.
- g) The appeal hearing described in subsection (d)(2) of this Section shall be held within 30 days after the date the appeal is filed.
- h) A transfer of resources under subsection (d) of this Section from the institutionalized spouse to the community spouse shall be made as soon as practicable after the date of initial determination of eligibility and before the first regularly scheduled redetermination of eligibility, taking into account such time as may be necessary to obtain a court order under subsection (d)(3) of this Section. If a transfer of resources to a community spouse has not been made by the first scheduled redetermination and no petition for an order of spousal support is pending judicial review, the resources shall be considered available to the institutionalized spouse.
- i) Assignment of Support Rights. The institutionalized spouse shall not be ineligible by reason of resources determined under subsection (c)(4) to be available for the cost of care when:
- 1) the institutionalized spouse has assigned to the State any rights to support from the community spouse (see Section 120.319);
  - 2) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the State has the right to bring a support proceeding against a community spouse without that assignment; or
  - 3) the State determines that denial of eligibility would work an undue hardship (see Section 120.388(r)(1)).
- j) Effective July 1, 2012, if an institutionalized spouse or community spouse refuses to provide the Department the total value of assets, including income and resources, to the extent either the institutionalized spouse or community spouse has ownership interest in them, that refusal may result in the institutionalized

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spouse being denied eligibility and continuing to remain ineligible for long term care based on failure to cooperate.

k) Effective July 1, 2012, the~~The~~ Department may pursue any available legal process to enforce its right of assignment to support against the community spouse or any other responsible person pursuant to Section 120.319.~~These processes may include, but shall not be limited to, the administrative support procedures provided under 89 Ill. Adm. Code 103.~~

- 1) The Department may seek support, for an institutionalized spouse who has assigned his or her right of support from his or her spouse to the State, from the resources and income available to the community spouse.
- 2) The Department may bring an action in the circuit court to establish support orders or itself establish administrative support orders by any means and procedures authorized under the Public Aid Code, as applicable, except that the standard and regulations for determining ability to support in Section 10-3 of the Public Aid Code shall not limit the amount of support that may be ordered.
- 3) Proceedings may be initiated to obtain support, or for the recovery of aid granted during the period support was not provided, or both, for the obtainment of support and the recovery of the aid provided. Proceedings for the recovery of aid may be taken separately or they may be consolidated with actions to obtain support. The proceedings may be brought in the name of the person or persons requiring support or may be brought in the name of the Department, as the case requires.
- 4) The orders for the payment of moneys for the support of the person shall be just and equitable and may direct support payment for the periods the circumstances require, including support for a period before the date the order for support is entered. In no event shall the orders reduce the community spouse resource allowance below the level established in subsection (d) or an amount set after a fair hearing pursuant to subsection (f), whichever is greater, or reduce the monthly maintenance allowance for the community spouse below the level permitted pursuant to subsection (e).

(Source: Amended at 37 Ill. Reg. 10208, effective June 27, 2013)

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**Section 120.380 Resources**

- a) Unless otherwise specified and for purposes of this Part, the term "resource" (as defined in 42 USC 1382b, except subsection (a)(1) of that section, which excludes the home as a resource) means cash or any other personal or real property that a person owns and has the right, authority or power to liquidate.
- b) A resource is considered available to pay for a person's own care when at the disposal of that person; when the person has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance or medical care; or when the person has the lawful power to make the resource available or to cause the resource to be made available.
- c) The value of nonexempt resources shall be considered in determining eligibility for any means-tested public benefit program administered by the Department, the Department of Human Services or the Department on Aging if eligibility is determined, in part, on the basis of resources as provided under this Section.
- d) Determination of Resources.
  - 1) In determining initial financial eligibility for medical assistance, the Department considers nonexempt verified resources available to a person as of the date of decision on the application for medical assistance. The date of verification (see Section 120.308(f)) may be prior to the date of decision. Resources applied to a spenddown obligation in a retroactive month (see Section 120.61(b)) shall not be treated as available in the determination of initial financial eligibility. Money considered as income for a month is not considered a resource for that same month. If income for a month is added to a bank account that month, the Department will subtract the amount of income from the bank balance to determine the resource level. Any income remaining in the following months is considered a resource.
  - 2) Effective July 1, 2012, an applicant for medical assistance may be eligible for up to 3 months prior to the date of application if the person would have been eligible for medical assistance at the time he or she received services if he or she had applied, regardless of whether the person is alive when the application for medical assistance is made. In determining financial eligibility for retroactive months, the Department will consider the amount of income, ~~and~~ resources and exemptions available to a person as of the

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first day of each of the backdated months for which eligibility is sought. ~~Resources spent prior to the end of the month of application to purchase a Pre-paid Funeral/Burial Contract in compliance with Section 120.381(b), (c) or (d), to pay for incurred medical expenses or to pay legal fees up to \$10,000 (which shall be adjusted annually for any increase in the Consumer Price Index), incurred in the month of application or in any of the three months prior to the month of application, that are related to the eligibility application for long term care assistance shall not be considered available.~~

- 3) In determining a person's spenddown obligation (see Section 120.384), the Department considers the amount of nonexempt resources available as of the date of decision, in the case of initial eligibility, and the first day of the month, in the case of retroactive eligibility, that are in excess of the applicable resource disregard (see Section 120.382).
- e) Subject to subsection (c) of this Section and 89 Ill. Adm. Code 113.140, the entire equity value of jointly held resources shall be considered available in determining a person's eligibility for assistance, unless:
- 1) The resource is a joint income tax refund, in which case one-half of the refund is considered owned by each person; or
  - 2) The person documents that he or she does not have access to the resource. Appropriate documents may include, but are not limited to, bank documents, signature cards, trust documents, divorce papers, and papers from court proceedings that show the person is legally unable to access the resource; or
  - 3) The resource is held jointly with an individual eligible under any means-tested public health benefit program (other than the Supplemental Nutrition Assistance Program) administered by the Department, the Department of Human Services, or the Department on Aging; or
  - 4) The person can document the amount of his or her legal interest in the resource and that such amount is less than the entire value of the resource, then the documented amount shall be considered. Appropriate documentation may include, but is not limited to, bank documents, trust documents, signature cards, divorce papers, or court orders that show the person's legal interest is less than the entire value of the resource; or

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- 5) The person documents that the resource or a portion of the resource is not owned by the person and the person's accessibility to the resource is changed (see subsections (e)(2) and (4) of this Section for documentation examples).
- f) In determining the eligibility of a person for long term care services whose spouse resides in the community, all nonexempt resources owned by the institutionalized spouse, the community spouse, or both shall be considered available to the institutionalized spouse in determining his or her eligibility for medical assistance. From the total amount of such resources may be deducted a Community Spouse Resource Allowance as provided under Section 120.379.
- g) Trusts established prior to August 11, 1993 shall be treated in the manner described in Section 120.346.
- h) Trusts established on or after August 11, 1993 shall be treated in the manner described in Section 120.347.
- i) The value of a life estate shall be determined at the time the life estate in the property is established and at the time the property (for example, resources) is liquidated. In determining the value of a life estate and remainder interest based on the value of the property at the time the life estate is established or of the amount received when the property is liquidated, the Department shall apply the values described in Section 120. Table A. The life estate and remainder interest are based on the age of the person at the time the life estate in the property is established and at the time the property is liquidated and the corresponding values described in Section 120. Table A.
- j) A person's entrance fee in a continuing care retirement community or life care community (as those entities are described in 42 USC 1396r(c)(5)(B)) shall be considered an available resource to the extent that:
- 1) the person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used to pay for care should other resources or income of the person be insufficient to pay for the care;
  - 2) the person is eligible for a refund of any remaining entrance fee when the person dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

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- 3) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.
- k) Non-homestead real property, including homestead property that is no longer exempt (see Section 120.381(a)(1)), is considered an available resource unless:
- 1) the property is exempted as income-producing to the extent permitted under Section 120.381(a)(3), except Section 120.381(a)(3) shall not apply to farmland property and personal property used in the income-producing operations related to the farmland (e.g., equipment and supplies, motor vehicles, tools, etc.) [through December 31, 2013](#);
  - 2) ownership of the property consists of a fractional interest of such a small value that a substantial loss to the person would occur if the property were sold;
  - 3) the property has been listed for sale, in which case the property will not be counted as available for at least six months as long as the person continues to make a good faith effort to sell the property. This effort can be verified by evidence, including advertisements or documentation of the listing of the property with licensed real estate agents or brokers that includes a report of any offer from prospective buyers. The Department will review cases in which the property has not been sold after six months and will consider the following factors in determining if extensions of the initial six months are warranted:
    - A) the asking price is less than the fair market value of the property;
    - B) the property is marketed through a qualified realtor who is acting in good faith;
    - C) there is not a substantial market for the type of property being sold; and
    - D) the person has not rejected any reasonable offer to buy the property; or
  - 4) the homestead property that is no longer exempt (see Section 120.381(a)(1)) is producing annual net income for the person in an amount

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that is not less than six percent of the person's equity value in the property. In determining net income, the Department shall recognize business expenses allowed for federal income tax purposes.

(Source: Amended at 37 Ill. Reg. 10208, effective June 27, 2013)

**Section 120.381 Exempt Resources**

- a) Effective July 1, 2012, the The following resources are exempt from consideration in determining eligibility for medical assistance:
  - 1) Homestead Property.
    - A) Homestead property is any property in which a person (and spouse, if any) has an ownership interest and that serves as the person's principal place of residence. This property includes the shelter in which a person resides, the adjoining land on which the shelter is located and related outbuildings.
    - B) If a person (and spouse, if any) moves out of his or her home without the intent to return, the home is no longer exempt because it is no longer the person's principal place of residence. If a person leaves his or her home to live in a long term care facility, the property is considered exempt, irrespective of the person's intent to return, as long as a spouse or dependent relative of the eligible person continues to live there. The person's equity in the former home is treated as an available resource effective with the first day of the month following the month it is no longer his or her principal place of residence.
    - C) Subject to federal approval, homestead property transferred to a trust is not exempt unless the Department determines that the person's spouse, minor child or disabled child resides in the property.
  - 2) Personal effects and household goods are exempt to the extent they are excluded under 20 CFR 416.1216.
  - 3) Resources (for example, land, buildings, equipment and supplies or tools), including, effective January 1, 2014, farmland property and personal

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property used in the income producing operations related to the farmland (for example, equipment and supplies, motor vehicles or tools), necessary for self-support up to \$6,000 of the person's equity in the income producing property are exempt provided the property produces a net annual income of at least six percent of the excluded equity value of the property. The equity value in excess of \$6,000 is not excluded. If the activity produces income that is less than six percent of the exempt equity due to reasons beyond the person's control (for example, the person's illness or crop failure) and there is a reasonable expectation that the property will again produce income equal to six percent of the equity value (for example, a medical prognosis that the person is expected to respond to treatment or that drought resistant corn will be planted), the equity value in the property up to \$6,000 is exempt. If the person owns more than one piece of property and each produces income, each is looked at to determine if the six percent rule is met and then the amounts of the person's equity in all of those properties are totaled to see if the total equity is \$6,000 or less. The total equity value of all properties that is exempt under this subsection is limited to \$6,000.

- 4) Automobile.
  - A) Exclude one automobile, regardless of value, used by the client, spouse or other dependent if:
    - i) it is necessary for employment;
    - ii) it is necessary for the medical treatment of a specific or regular medical problem;
    - iii) it is modified for operation by, or transportation of, a handicapped person;
    - iv) it is necessary because of factors such as climate, terrain or distance to provide necessary transportation to perform essential daily activities; or
    - v) one vehicle for each spouse is exempt in determining the amount allowed as the Community Spouse Resource Allowance (as described in Section 120.379(d)).

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- B) If not excluded in subsection (a)(4)(A) of this Section, one automobile is excluded to the extent its equity value does not exceed \$4500. Any excess equity value is applied toward the applicable resource disregard (see Section 120.382).
  - C) For all other automobiles, apply the equity value toward the resource disregard (see 89 Ill. Adm. Code 113.142).
- 5) Life insurance policies with a total face value of \$1,500 or less and all term life insurance policies. If the total face value exceeds \$1,500, the cash surrender value must be counted as a resource.
- 6) For purposes of this Section, the term "equity value" refers to:
- A) in the case of real property, the value described in Section 120.385(c); and
  - B) in the case of personal property, the price that an item can reasonably be expected to sell for on the open market in the particular geographic area involved, minus any encumbrances (as described in Section 120.385(c)(1)(C)).
- b) Burial spaces that are intended for the use of the person, his or her spouse, or any other member of his or her immediate family are exempt. Immediate family is defined as a person's minor and adult children, including adopted children and stepchildren, a person's brothers, sisters, parents and adoptive parents, and the spouses of these individuals.
- c) Funds that are set aside for the burial expenses of a person and his or her spouse in a bank account owned by the person that is clearly identified as a burial fund is exempt up to \$1500. This amount is reduced by the face value of any excluded life insurance on the person and the amount of any funds held in an irrevocable trust or other irrevocable arrangement that is available for burial expenses per person.
- d) Prepaid Funeral/Burial Contracts. Prepaid funeral/burial contracts are exempt to the following extent:
- 1) Funds in a revocable prepaid funeral/burial contract are exempt up to \$1500, except that any portion of a contract that clearly represents the

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purchase of burial space, as that term is defined for purposes of the Supplemental Security Income program, is exempt regardless of value.

- 2) Funds Effective January 1, 2012, funds in an irrevocable prepaid funeral/burial contract are exempt up to \$5,874~~\$10,000~~, except that any portion of a contract that clearly represents the purchase of burial space, as that term is defined for purposes of the Supplemental Security Income program, is exempt regardless of value~~which shall include the costs of both goods and services~~. This amount shall be adjusted annually for any increase in the Consumer Price Index. The amount exempted shall be limited to the price of the funeral goods and services to be provided upon death. The contract must provide a complete description of the funeral goods and services to be provided and the price of those goods and services. Any amount in the contract not so specified shall be treated as a transfer of assets for less than fair market value.
  - 3) A prepaid, guaranteed price funeral/burial contract ~~up to \$10,000, which shall include the costs of both goods and services and which shall be adjusted annually for any increase in the Consumer Price Index~~, funded by an irrevocable assignment of a person's life insurance policy to a trust, is exempt. The amount exempted shall be limited to the amount of the insurance benefit designated for the cost of the funeral goods and services to be provided upon the person's death. The contract must provide a complete description of the funeral goods and services to be provided and the price of those goods and services. Any amount in the contract not so specified shall be treated as a transfer of assets for less than fair market value. The trust must include a statement that, upon the death of the person, the State will receive all amounts remaining in the trust, including any remaining payable proceeds under the insurance policy up to an amount equal to the total medical assistance paid on behalf of the person. The trust is responsible for ensuring that the provider of funeral services under contract receives the proceeds of the policy when it provides the funeral goods and services specified under the contract. The irrevocable assignment of ownership of the insurance policy must be acknowledged by the insurance company.
- e) Resources necessary for fulfillment of an approved plan for achieving self-support under 42 CFR 416.1220.
  - f) Resources excluded by express provision of 20 CFR 416.1236 (2009).

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- g) *Donations or benefits from fund raisers held for a seriously ill client provided the client or a responsible relative of the client does not have control (for example, not available to the client or the responsible relative) over the donations or benefits or the disbursement of donations or benefits [305 ILCS 5/5-2].*
- h) Payments made to veterans who receive an annual disability payment or to the survivors of deceased veterans who receive a one-time lump sum payment from the Agent Orange Settlement Fund or any other fund referencing Agent Orange product liability under Public Law 101-201.
- i) Money received from the Social Security Administration under a Plan to Achieve Self-Support (PASS) and held in a separate account.
- j) Disaster relief payments provided by federal, State or local government or a disaster assistance organization.
- k) The amount of earned income tax credit that the client receives as advance payment or as a refund of federal income tax.
- l) For disabled persons who have lost eligibility under Section 120.510 and who are only requesting services other than those described in Section 120.61(a) (except that subsection's reference to services provided through a Community Integrated Living Facility (CILA)), the following additional exemptions shall apply:
  - 1) Retirement accounts that a person with a disability cannot access without penalty before the age of 59½ and medical savings accounts established pursuant to 26 USC 220; and
  - 2) Up to \$25,000 if the person owned assets of equal value when his or her eligibility under Section 120.510 ended.
- m) The amount of damages recovered by a resident of a nursing home for any act that injures the resident pursuant to 210 ILCS 45/3-605.
- n) Certain payments received under the American Recovery and Reinvestment Act of 2009.
  - 1) Payments to World War II veterans who served in the Philippines and spouses of those veterans under Div. A, Title X, Sec. 1002 of P.L. 111-5.

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- 2) Payments or reimbursements for Premium Assistance for COBRA Continuous Coverage under Div. B, Title III, Sec. 3001 of P.L. 111-5.
- o) Certain payments received under the American Recovery and Reinvestment Act of 2009 are exempt as an asset the month of receipt and two months thereafter.
  - 1) Making Work Pay Credit under Div. B, Title I, Sec. 1001 of P.L. 111-5.
  - 2) Tax Credit for Certain Government Retirees under Div. B, Title II, Sec. 2202 of P.L. 111-5.
- p) Economic Recovery Payments under the American Recovery and Reinvestment Act of 2009 under Div B, Title II, Sec. 2201 of P.L. 111-5 are exempt as an asset the month of receipt and nine months thereafter.

(Source: Amended at 37 Ill. Reg. 10208, effective June 27, 2013)

**Section 120.385 Factors Affecting Eligibility for Long Term Care Services**

- a) For purposes of this Section, the terms "institutionalized persons" and "long term care services" shall have the meanings described in Section 120.388 of this Part. The terms "institutionalized spouse" and "community spouse" shall have the meanings described in Section 120.379(a) of this Part.
- b) Disclosure of Annuity and Naming the State as Remainder Beneficiary.
  - 1) Effective January 1, 2012, an application (or redetermination related to an application) for long term care services shall include a disclosure by an institutionalized person or his or her community spouse of any interest either or both may have in any annuity or similar financial instrument purchased, regardless of whether the annuity is irrevocable or is treated as an asset. The application or recertification form shall also include a statement that the State of Illinois becomes a remainder beneficiary under such an annuity or similar financial instrument to the extent that the State has provided medical assistance to the institutionalized person.
  - 2) Failure of an institutionalized person, his or her community spouse, or his or her representative to disclose information or to name the State as a remainder beneficiary as provided for in subsection (b)(1) of this Section,

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or to disclose sufficient information regarding an annuity in order to establish eligibility for long term care services, shall result in denial or termination of the eligibility. Failure of an institutionalized person, his or her community spouse or his or her representative to disclose the information provided for in subsection (b)(1) of this Section, or to disclose sufficient information regarding an annuity in order to establish eligibility for medical assistance, may also result in denial or termination of eligibility for failure to cooperate under Section 120.308.

## c) Home Equity Interest.

- 1) ~~Effective July 1, 2012, a~~~~Effective January 1, 2012, a~~ person shall not be eligible for long term care services if the person's equity interest in his or her homestead exceeds ~~the minimum home equity allowed and increased annually under federal law (42 USC 1396p(f)(1)(C)), which, for calendar year 2012, was \$525,000.~~~~\$750,000.~~ This amount shall be increased, beginning with 2013, from year to year based on the percentage increase in the Consumer Price Index for all urban consumers (all items: United States city average), rounded to the nearest \$1000. A person's equity interest in his or her homestead shall be determined as follows:

- A) The current market value (CMV) of the property is the going price for which it can reasonably be expected to sell on the open market in the particular geographic area involved. The CMV of the property may be established by:
- i) an appraisal report, no more than six months old at the time of the application for long term care services, completed by an appraiser who is licensed or otherwise meets the requirements under the Real Estate Appraiser Licensing Act [225 ILCS 458]; or
  - ii) a county real estate assessor's current estimate of the market value or fair cash value of the property used in determining the assessed value of a property; or
  - iii) any other reliable and verifiable indicia of the price that a property would bring in a sale between a willing buyer and seller under arms-length conditions unaffected by undue pressures;

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- B) Equity value (EV) is the CMV of the property minus any encumbrance on it;
  - C) An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property but does not necessarily prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell, the creditor will nearly always require debt satisfaction from the proceeds of sale. Examples of encumbrances include mortgages, reverse mortgages, home equity loans or other debt that is secured by the property;
  - D) If property is held in any form of shared ownership (e.g., joint tenancy, tenancy in common or other similar arrangement) only the fractional interest in the property shall be considered in determining the person's equity in that property.
- 2) The eligibility of a person for long term care services shall not be affected under this subsection (c) if any of the following are lawfully residing in the person's home:
- A) the person's spouse;
  - B) the person's child who is under age 21; or
  - C) the person's adult child who is blind (as described in Section 120.313 of this Part) or disabled (as described in Section 120.314 of this Part).
- 3) A person whose eligibility for long term care services is affected under this subsection (c) may request a hardship waiver. The process and basis for requesting such a waiver shall be the same as described in Section 120.388(r) of this Part. In determining whether a waiver should be granted, the Department shall also take into account:
- A) the amount of time the person has resided in and owned the home;
  - B) whether a substantial increase in property values in the home's geographic area occurred after the person purchased the home;

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- C) whether the home comprises a substantial portion of the person's assets (as defined in Section 120.388(d)); and
  - D) whether the person intends to return to the home after a period of institutionalization or, if the person does not intend to return, whether the home can be sold after being listed for sale or, if it cannot be sold, can produce income commensurate with similar income producing properties in the geographic area.
- 4) For purposes of this Section the words, "homestead" and "home" have the same meaning as the term "homestead" in Section 120.381(a)(1)(A) of this Part.
- d) Disclosure of Purchase of Promissory Notes, Loans and Mortgages and Assigning Interest to the State.
- 1) Effective January 1, 2012, an application (or redetermination related to an application) for long term care services shall include a disclosure by an institutionalized person or his or her community spouse of any purchase of a promissory note, loan or mortgage either or both may have made. The application or recertification form shall also include a statement that the instrument shall provide for the assignment to the State of Illinois, as of the date of death, of up to the total amount of medical assistance paid on behalf of the institutionalized person.
  - 2) Failure of an institutionalized person, his or her community spouse, or his or her representative to disclose information or to assign interest to the State as provided for in subsection (d)(1) of this Section, or to disclose sufficient information regarding a promissory note, loan or mortgage in order to establish eligibility for long term care services, shall result in denial or termination of the eligibility. Failure of an institutionalized person, his or her community spouse, or his or her representative to disclose the information provided for in subsection (d)(1) of this Section, or to disclose sufficient information regarding a promissory note, loan or mortgage in order to establish eligibility for medical assistance, may also result in denial or termination of eligibility for failure to cooperate under Section 120.308.

(Source: Amended at 37 Ill. Reg. 10208, effective June 27, 2013)

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- 1) Heading of the Part: Covering All Kids Health Insurance Program
- 2) Code Citation: 89 Ill. Adm. Code 125
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
125.110	Amendment
125.200	Amendment
125.205	Amendment
125.220	Amendment
125.225	Amendment
125.240	Amendment
125.245	Amendment
125.250	Amendment
125.260	Amendment
125.265	Repeal
125.300	Amendment
125.305	Amendment
125.310	Amendment
125.320	Amendment
125.330	Amendment
125.340	Amendment
125.400	Amendment
125.420	Amendment
125.430	Amendment
125.440	Amendment
125.445	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: February 1, 2013; 37 Ill. Reg. 992 and April 12, 2013; 37 Ill. Reg. 4420

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- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: The following changes have been made:
- In Section 125.200 added "Effective July 1, 2012".
- In Section 125.205(c) added "Effective July 1, 2012".
- In Sections 125.240(b) and (c) added "Effective July 1, 2012".
- In Section 125.310(a) at the beginning of the sentence added "Effective July 1, 2012,"; changed "Copayments" and "copayments"
- In Section 125.310(b) changed "July 1, 2013" to "July 1, 2012" and added ",subject to federal approval:" at the end of the sentence after "follows".
- In Section 125.310(b)(1)(A) added "in federal regulations" before "at 42 CFR 447.54," and added "which for dates of services beginning July 1, 2012 through March 31, 2013 is \$3.65. Beginning April 1, 2013, the nominal copayment amount is \$3.90" after "42 CFR 447.54".
- In Section 125.310(b)(2)(A) deleted "daily" added "in federal regulations" before "at 42 CFR 447.54 et seq.," and added "which for dates of services beginning July 1, 2012 through March 31, 2013 is \$3.65 per admission. Beginning April 1, 2013, the nominal copayment amount is \$3.90 per day." after "42 CFR 447.54 et. seq.,"
- In Section 125.310(b)(3)(A) added "in federal regulations" before "at 42 CFR 447.54," and added "which for dates of services beginning July 1, 2012 through March 31, 2013 is \$3.65. Beginning April 1, 2013, the nominal copayment amount is \$3.90" after "42 CFR 447.54".
- In Section 125.310(b)(4)(A) added "in federal regulations" before "at 42 CFR 447.54," and added "which for dates of services beginning July 1, 2012 through March 31, 2013 is \$3.65. Beginning April 1, 2013, the nominal copayment amount is \$3.90" after "42 CFR 447.54".

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In Section 125.340(g) changed language to read as follows: "Effective July 1, 2012, in each instance in which a copayment is payable, the Department will reduce the amount payable to the provider by the respective amount of the required payment."

- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace an emergency rulemaking currently in effect? Yes, July 13, 2012; 36 Ill. Reg. 10298.
- 14) Are there any other proposed rulemakings pending on this Part? No
- 15) Summary and Purpose of Amendments: Part 125 is being amended to comply with the reduction in FamilyCare eligibility mandated by PA 97-689, the SMART Act. Effective July 1, 2012, FamilyCare eligibility is limited to individuals in families with income at or below 133 percent of the federal poverty level as established in 89 Ill. Adm. Code 120.32. The rulemaking also makes name changes to avoid inadvertent establishment of provisions, necessary to implement SMART that could be construed as conflicting with other parts of Title 89. For example, KidCare is changed to All Kids because the name KidCare is no longer used and Premium is changed to Premium Level 1 to avoid confusion with the Premium Level. In addition, this rulemaking includes changes necessary to bring the rule into compliance with recent statutory changes made in P.A. 96-1501 regarding reinstatement of benefits and P.A. 96-1272 regarding elimination of the three-month penalty period for reenrollment. Further, Part 125 is being amended to comply with the copayment requirements mandated by PA 97-689, the SMART Act.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

The full text of the Adopted Amendments begins on the next page:

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## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## SUBCHAPTER b: ASSISTANCE PROGRAMS

## PART 125

## CHILDREN'S HEALTH INSURANCE PROGRAM

## SUBPART A: GENERAL PROVISIONS

## Section

125.100 General Description

125.110 Definitions

## SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

## Section

| 125.200 Eligibility for Children's Health Insurance Program ~~and Family Care~~

125.205 Eligibility Exclusions and Terminations

125.220 Application Process

125.225 Presumptive Eligibility for Children

125.230 Determination of Monthly Countable Income

125.240 Eligibility Determination and Enrollment Process

125.245 Appeals

125.250 Annual Renewals

125.260 Adding Children to the Program and Changes in Participation

| 125.265 Adding Eligible Adults to the Program and Changes in Participation (Repealed)| SUBPART C: ALL KIDSKIDCARE/FAMILYCARE HEALTH PLAN

## Section

125.300 Covered Services

125.305 Service Exclusions

125.310 Copayments

125.320 Premium Requirements

125.330 Non-payment of Premium

125.340 Provider Reimbursement

| SUBPART D: ALL KIDSKIDCARE/FAMILYCARE REBATE

## Section

125.400 Minimum Coverage Requirements

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- 125.420 Coverage Verification Process  
125.430 Provision of Policyholder's Social Security Number  
125.440 ~~All Kids KidCare/FamilyCare Insurance~~ Rebate  
125.445 Rebate Overpayments

AUTHORITY: Implementing and authorized by the Children's Health Insurance Program Act [215 ILCS 106] and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13].

SOURCE: Adopted by emergency rulemaking at 22 Ill. Reg. 15706, effective August 12, 1998, for a maximum of 150 days; adopted at 23 Ill. Reg. 543, effective December 24, 1998; emergency amendment at 24 Ill. Reg. 4217, effective March 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11822, effective July 28, 2000; amended at 26 Ill. Reg. 12313, effective July 26, 2002; emergency amendment at 26 Ill. Reg. 15066, effective October 1, 2002, for a maximum of 150 days; amended at 27 Ill. Reg. 4723, effective February 25, 2003; emergency amendment at 27 Ill. Reg. 10807, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18623, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 7163, effective May 3, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13632, effective September 28, 2004; emergency amendment at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 10328, effective May 26, 2006; emergency amendment at 36 Ill. Reg. 10298, effective July 1, 2012 through June 30, 2013; emergency amendment at 37 Ill. Reg. 5049, effective April 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 10253, effective June 27, 2013.

## SUBPART A: GENERAL PROVISIONS

**Section 125.110 Definitions**

For the purpose of this Part, the following terms shall be defined as follows:

"Act" means the Children's Health Insurance Program Act [215 ILCS 106].

"All Kids Health Plan" means the health benefits coverage containing cost sharing features that is available to eligible children under the Act and includes All Kids Share (no premium required) and All Kids Premium Level 1 (premium required).

"All Kids Rebate" means the program available under the Act for which the Department, on behalf on an eligible child, makes rebate payments to offset a family's cost of insuring that child under privately sponsored or employer-based health insurance.

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"Caretaker Relative" means a relative as specified in this definition, with whom the child lives, who is providing care, supervision and a home for the child. Caretaker relatives include:

Blood or adoptive relatives within the fifth degree of kinship:

father and mother

brother and sister

grandmother and grandfather (including up to great-great-great)

uncle and aunt (including up to great-great)

nephew and niece (including up to great-great)

first cousin

first cousin once removed (child of first cousin)

second cousin (child of great-aunt/uncle)

Step relatives:

step-father and step-mother

step-brother and step-sister

A person who is or has been married to one of the above relatives.

"Department" means the Department of Healthcare and Family Services and any successor agencies.

"Eligible Adult" means an individual 19 years of age or older who is a parent or other caretaker relative and that individual's spouse if they reside together.

"Family" means the child applying for the Program and the following individuals who live with the child:

The child's parents

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The spouse of the child's parent

Children under 19 years of age of the parents or the parent's spouse

The spouse of the child

The children of the child

If any of the above is pregnant, the unborn children.

"FamilyCare Premium" means ~~expansion of~~ coverage of parents and caretaker relatives in families with income above 150 percent of the Federal Poverty Level. The FamilyCare Premium program ceased effective June 30, 2012, but unpaid premiums may be relevant to children's eligibility under this Part to include eligible adults as permitted by the KidCare Parent Coverage Waiver.

"FamilyCare Rebate" means the program under which the Department, on behalf of an eligible adult, made rebate payments to offset a family's cost of insuring an individual under privately sponsored or employer-based health insurance. The FamilyCare Rebate program ceased effective June 30, 2012, but unreturned overpayments may be relevant to children's eligibility under this Part.

"Federal Poverty Level" means the federal poverty income guidelines as established by the federal Department of Health and Human Services and published in the Federal Register.

"KidCare/FamilyCare Health Plan" means ~~the health benefits coverage containing cost sharing features that is available to eligible families under the Children's Health Insurance Program or the KidCare Parent Coverage Waiver, and includes KidCare/FamilyCare Share (no premium required) and KidCare/FamilyCare Premium (premium required).~~

"KidCare/FamilyCare Rebate" means ~~the program under which the Department, on behalf of an eligible individual, makes rebate payments to offset a family's cost of insuring an individual under privately sponsored or employer-based health insurance.~~

"Medical Assistance" means health care benefits provided under Article V of the Illinois Public Aid Code.

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"Program" means the program created under the Children's Health Insurance Program Act and this Part.

"Rebate" means the payment made by the Department under ~~All KidsKidCare~~ Rebate.

"REV" means the Recipient Eligibility Verification system through which medical providers can obtain eligibility and claim status information electronically.

"Significant Health Insurance" means coverage that includes physician services and inpatient hospital services that would qualify for coverage under ~~All KidsKidCare~~ Rebate.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

## SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

**Section 125.200 Eligibility for Children's Health Insurance Program ~~and FamilyCare~~**

Effective July 1, 2012, a~~A~~ child ~~or eligible adult~~ may be eligible under the Program provided that all of the following eligibility criteria are met:

- a) The child ~~or eligible adult~~ is not eligible for Medical Assistance, including 89 Ill. Adm. Code~~Section 120.32~~.
- b) The child is under 19 years of age.
- c) Countable Income
  - 1) A child is a member of a family whose monthly countable income is above 133 percent of the Federal Poverty Level and at or below 200 percent of the Federal Poverty Level.
  - 2) ~~An eligible adult is a member of a family whose monthly income is above 133 percent of the Federal Poverty Level and at or below 185 percent of the Federal Poverty Level.~~
- d) The individual is a resident of the State of Illinois.

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- e) The individual is either a United States citizen or included in one of the following categories of non-citizens:
- 1) United States veterans honorably discharged or individuals on active military duty, or the spouse or unmarried dependent children of such persons.
  - 2) Refugees under ~~section~~Section 207 of the Immigration and Nationality Act ([8 USC 1157](#)).
  - 3) Asylees under ~~section~~Section 208 of the Immigration and Nationality Act.
  - 4) Individuals for whom deportation has been withheld under ~~section~~Section 243(h) of the Immigration and Nationality Act.
  - 5) Individuals granted conditional entry under ~~section~~Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980.
  - 6) Individuals lawfully admitted for permanent residence under the Immigration and Nationality Act.
  - 7) Parolees, for at least one year, under ~~section~~Section 212(d)(5) of the Immigration and Nationality Act.
  - 8) Nationals of Cuba or Haiti.
  - 9) Individuals identified by the Federal Office of Refugee Resettlement (ORR) as victims of trafficking.
  - 10) Amerasians from Vietnam.
  - 11) Members of the Hmong or Highland Laotian tribe when the tribe helped United States personnel by taking part in military or rescue operations.
  - 12) American Indians born in Canada.
  - 13) Individuals who are a spouse, widow or child of a United States citizen or a spouse or a child or a legal permanent resident (LPR) who have been battered or subjected to extreme cruelty by the United States citizen or LPR or a member of that relative's family who lived with them, who no

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longer live with the abuser or plan to live separately within one month after assistance and whose need for assistance is due, at least in part, to the abuse.

- f) The individual's Social Security Number (SSN) is provided to the Department, or, if it has not been issued or is not known, proof that application has been made for an SSN is provided.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.205 Eligibility Exclusions and Terminations**

- a) An individual shall not be determined eligible for coverage under the Program if:
- 1) The individual is an inmate of a public institution.
  - 2) The individual is a patient in an institution for mental diseases.
  - 3) The individual is a member of a family that is eligible for health benefits coverage under a State of Illinois health benefits plan on the basis of a member's employment with a public agency.
  - 4) The individual is in categories described in Section 125.200(e)(6) or (e)(7), and the individual entered the United States on or after August 22, 1996; he or she shall not be eligible for five years beginning on the date the individual entered the United States.
- b) An individual with significant health insurance can choose between [All Kids KidCare/FamilyCare](#) Health Plan and [All Kids KidCare/FamilyCare](#) Rebate.
- c) ~~Effective July 1, 2012, termination-Termination~~ of an individual's coverage under the Program shall be initiated upon the occurrence of any of the following events:
- 1) A child becomes ineligible due to:
    - A) Losing his or her Illinois residency.
    - B) Attaining 19 years of age.
    - C) Becoming enrolled in Medical Assistance.

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- D) Meeting the provisions of subsection (a)(1) or (a)(3) of this Section.
- ~~2)~~ ~~An eligible adult becomes ineligible due to:~~
- A) ~~Losing his or her Illinois residency.~~
- B) ~~No child under 19 years of age remaining in the family.~~
- C) ~~Becoming enrolled in Medical Assistance.~~
- D) ~~Meeting the provisions of subsection (a)(1) or (a)(3) of this Section.~~
- E) ~~Income exceeding the range established in Section 125.200(b)(2).~~
- 23) A child ~~or an eligible adult~~ becomes ineligible due to:
- A) The required premiums under the All KidsKidCare/FamilyCare Health Plan are not paid, as specified in Sections 125.320 and 125.330.
- B) An individual enrolled in All KidsKidCare Rebate is no longer being covered under a private or employer-based health insurance plan, except that an individual may change enrollment from All KidsKidCare/FamilyCare Rebate to the All KidsKidCare/FamilyCare Health Plan pursuant to Section 125.260(c).
- C) The individual fails to report to the Department changes in information that impacts upon the individual's eligibility for the Program.
- D) The individual makes a request to the Department to terminate the coverage.
- E) The Department determines that the individual is no longer eligible based on any other applicable State or federal law or regulation.

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- F) The Department determines that the individual failed to provide eligibility information that was truthful and accurate to the best of the applicant's knowledge and belief and that affected the eligibility determination.
  - G) There has been a Rebate overpayment and it has not been repaid to the Department according to terms established by the Department, which may include recoupment out of future Rebate payments or a payment plan.
  - H) The Department determines that the individual's eligibility was incorrectly determined.
  - I) The application was approved pending receipt of the individual's Social Security Number and it is not provided later when requested.
- d) Following termination of an individual's coverage under the Program, the following action is required before the individual can be re-enrolled:
- 1) A new application must be completed and the individual must be determined otherwise eligible;
  - 2) There must be full payment of premiums under the [All KidsKidCare](#) Health Plan, for periods in which a premium was owed and not paid for the individual, including premiums owed when the individual was, for purposes of this Part, a member of another family;
  - 3) Any overpayment of Rebates paid on behalf of the individual must be repaid to the Department. A Rebate overpayment shall be considered repaid if the Department can recoup the overpayment out of future Rebate payments;
  - 4) If the termination was the result of non-payment of premiums, the individual must be out of the Program for three months before re-enrollment; and
  - 5) The first month's premium must be paid if the individual is eligible for [All KidsKidCare/FamilyCare](#) Premium and the individual's family chose to have coverage under subsection (g) of this Section when the individual

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was initially enrolled in the Program or if there was an unpaid premium on the date the individual's previous case was canceled.

- e) An application will be denied if any of the ~~eligible~~ adults in the family was responsible as a caretaker relative or was enrolled in FamilyCare Premium eligible adult during a period for which a premium under the Program was due to the Department and the premium remains unpaid at the time of application. Such an application shall be denied regardless of whether the individual for whom the premium remains unpaid is included in the application.
- f) An application will be denied if any of the eligible adults in the family was enrolled in FamilyCare Rebate received benefits or was a caretaker relative of a child during a period for which a Rebate overpayment was received or was the payee of a Rebate overpayment and the overpayment has not been repaid to the Department. Such an application shall be denied regardless of whether the individual for whom the Rebate overpayment remains unpaid is included in the application.
- g) A certificate of prior creditable coverage will be issued when the individual's coverage is terminated under the All KidsKidCare/FamilyCare Health Plan.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.220 Application Process**

- a) Families will be able to apply for the Program using any of the following methods:
  - 1) Submit the Department's application to an address specified by the Department.
  - 2) Apply at a Department of Human Services (DHS) local office.
  - 3) Apply through an All Kidsa-KidCare Application Agent that has an agreement in place with the Department.
  - 4) Apply online at www.allkids.comwww.kidcareillinois.com.
  - 5) Additional methods that the Department establishes.

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- b) The application will meet all requirements found at 89 Ill. Adm. Code 110.10.
- c) Families are obligated to provide truthful and accurate information for determining eligibility and to report promptly to the Department any change in non-financial information provided on the application or financial information for eligible adults.
- d) The Department may cease accepting or processing applications if enrollment in the Program is closed due to limited appropriations.
- e) The Department shall send a notification of its determination within 45 calendar days after the date the application was received.
- f) The 45 calendar days may be extended when a decision cannot be reached because:
  - 1) information necessary for a determination is available only from a third party and the party fails to respond or delays his or her response to the request for such information, or
  - 2) additional information is needed from the applicant.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.225 Presumptive Eligibility for Children**

- a) A child younger than 19 years of age may be presumed eligible for [an All Kidsa KidCare](#) Health Plan under this Part if all of the following apply:
  - 1) an application for medical benefits has been made on behalf of the child;
  - 2) the child is a resident of Illinois;
  - 3) the child is not an inmate of a public institution as described in Section 125.205(a)(1);
  - 4) the child is a member of a family whose monthly countable income, as stated on the application, is above 133 percent of the Federal Poverty Level and at or below 200 percent of the Federal Poverty Level;

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- 5) the State employee who registers the application has no information that the child is not a U.S. citizen or a qualified non-citizen as described in 89 Ill. Adm. Code 125.200(e) or 89 Ill. Adm. Code 118.500; and
  - 6) the child has not been presumed eligible under this Part 125 or 89 Ill. Adm. Code 118 or 120 within the past 12 months.
- b) Entities qualified to make a determination of presumptive eligibility include State employees involved in enrolling children in programs under this Part 125 or 89 Ill. Adm. Code 118 or 120.
  - c) The presumptive eligibility period begins on the date of application.
  - d) The presumptive eligibility period ends on the date the State's determination of the child's eligibility under this Part 125 or 89 Ill. Adm. Code 118 or 120 is updated in the data system.
  - e) No copayment or premium requirements apply during the period of presumptive eligibility.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.240 Eligibility Determination and Enrollment Process**

- a) If the monthly countable income is at or below 133 percent of the Federal Poverty Level for the number of individuals in the family, the individual will be enrolled in Medical Assistance, if otherwise determined eligible pursuant to 89 Ill. Adm. Code 120, Subpart H.
- b) Effective July 1, 2012, if the monthly countable income is above 133 percent and at or below 200 percent of the Federal Poverty Level for a child, ~~or at or below 185 percent of the Federal Poverty Level for an adult,~~ for the number of individuals in the family, and all other eligibility requirements of this Part are met and enrollment is open, the individual will be enrolled in the Program.
- c) Effective July 1, 2012, for purposes of cost sharing, ~~children~~ families in the All KidsKidCare/FamilyCare Health Plan will be enrolled into either All KidsKidCare/FamilyCare Share or All KidsKidCare/FamilyCare Premium as follows:

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- 1) If monthly countable income is above 133 percent and at or below 150 percent of the Federal Poverty Level for the number of individuals in the family, the individual will be enrolled in All KidsKidCare/FamilyCare Share.
  - 2) If monthly countable income is above 150 percent and at or below 200 percent of the Federal Poverty Level for the number of individuals in the family, a child will be enrolled in All KidsKidCare Premium. ~~or, if monthly countable income is above 150 percent and at or below 185 percent of the Federal Poverty Level for the number of individuals in the family, an eligible adult will be enrolled in FamilyCare Premium.~~
- d) Applicants will be notified, in writing, regarding the outcome of their eligibility determination.
- e) Eligibility determinations for the Program made by the 15<sup>th</sup> fifteenth day of the month will be effective the first day of the following month. Eligibility determinations for the Program made after the 15<sup>th</sup> fifteenth day of the month will be effective no later than the first day of the second month following that determination. The duration of eligibility for the Program for children will be 12 months unless one of the events described in Section 125.205(c)(1) or (c)(3) occurs. The 12 months of eligibility will commence when the first child in a family is covered under the Program. Children added to the Program after the eligibility period begins will be eligible for the balance of the 12-month eligibility period.
- f) Individuals determined to be eligible for the All KidsKidCare/FamilyCare Health Plan may obtain coverage for a period prior to the date of application for the Program. This coverage shall be subject to the following:
- 1) The family must request the prior coverage for the individual within six months following the initial date of coverage under the All KidsKidCare/FamilyCare Health Plan.
  - 2) The prior coverage will be individual specific and will only be available the first time the individual is enrolled in the Program.
  - 3) The prior coverage will begin with services rendered during the two weeks prior to the date the individual's application for the All KidsKidCare/FamilyCare Health Plan was filed and will continue until the

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individual's coverage under the All KidsKidCare/FamilyCare Health Plan is effective pursuant to subsection (e).

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.245 Appeals**

- a) Any person who applies for or receives assistance under the Program shall have the right to appeal any of the following actions:
  - 1) Refusal to accept an application.
  - 2) Denial of an application or cancellation at the annual renewal, including denial based on failure to meet one or more of the eligibility requirements specified in this Part. If the denial or cancellation is not upheld on appeal, coverage under the Program shall be retroactive to the date the coverage would have commenced had the application or annual determination been approved. However, if the individual is eligible for All KidsKidCare/FamilyCare Premium Level 1, it will be at the family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date the coverage would have commenced had the application been approved. All premium and copayment requirements shall apply to the retroactive period.
  - 3) Termination of coverage based on failure to continue to meet one or more of the eligibility requirements specified in this Part. If the termination is not upheld on appeal and benefits were not continued during the appeal, coverage under the Program shall be reinstated retroactive to the termination date. However, if an individual is eligible for All KidsKidCare/FamilyCare Premium Level 1, it will be at the family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date of termination. All premium and copayment requirements shall apply to any retroactive period.
  - 4) Determination of the amount of the premium, Rebate, or copayments required. Coverage, Rebate amount and any premium or copayment requirements, as determined by the Department, shall remain in force during the appeal process.

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- b) In addition to the actions that are appealable under subsection (a) of this Section, individuals covered under the ~~All Kids~~~~KidCare/FamilyCare~~ Health Plan shall have the right to appeal any of the following actions:
- 1) Termination of coverage due to non-payment of the required premium.
  - 2) Denial of payment for a medical service or item that requires prior approval.
  - 3) Decision granting prior approval for a lesser or different medical service or item than was originally requested.
- c) The Department's decision to deny an application due to closing of enrollment for the Program shall not be appealable.
- d) Individuals may initiate the appeal process by:
- 1) Filing a written, signed request for a hearing directed to the Department's Assistance Hearings Section;
  - 2) Calling a toll free telephone number (800/435-0774, or as designated by the Department).
- e) The request for a hearing may be filed by the individual affected by the action or by the individual's authorized representative.
- f) For purposes of initiating the appeal process, a copy of a written, signed request for a hearing is considered the same as the original written, signed request.
- g) The request for a hearing must be filed no later than 60 days after notice of the appealable action has been given.
- h) If an appeal is initiated within ~~10~~~~ten~~ calendar days after the notice of intended Department action and the individual specifically requests that the benefits be continued, benefits shall be continued at the level in effect prior to the proposed action, pending the results of the fair hearing process. All copayment obligations, including premiums, must be met during the period.
- i) The provisions of Subpart A of the Department's administrative rules at 89 Ill.

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Adm. Code 104, Practice in Administrative Hearings, shall govern the handling of appeals and the conduct of hearings under the Program.

- j) An individual can, prior to a decision being rendered on the appeal, reapply for the Program.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.250 Annual Renewals**

- a) Eligibility shall be reviewed by the Department, or its authorized agent, at least annually following the process set forth in Sections 11-5.1 through 11-5.3 of the Public Aid Code.
- ~~b) Prior to the 12-month eligibility period ending, and in sufficient time for the Family to respond to the Department's request for information, the Department or its designee will send an annual renewal notice to the Family.~~
- be) Annual renewals shall be subject to all eligibility requirements set forth in Sections 125.200 and 125.205.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.260 Adding Children to the Program and Changes in Participation**

- a) Families may add eligible children to the Program during the 12-month eligibility period, without eligibility being reviewed by the Department. Coverage for children added shall be prospective from the effective date determined according to Section 125.240(e) and shall continue for the remainder of the family's original 12-month eligibility period and may also include any prior coverage established pursuant to Section 125.240(f).
- b) Premium amounts under the All KidsKidCare Health Plan and Rebates under All KidsKidCare Rebate will be adjusted to reflect adding or removing a child from the Program.
- c) A child who would otherwise be terminated from All KidsKidCare Rebate because of losing private or employer-sponsored health insurance may change coverage to the All KidsKidCare Health Plan without eligibility being reviewed by the Department if there is no unpaid Rebate overpayment. Coverage under the

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All KidsKidCare Health Plan shall be prospective from the effective date determined according to Section 125.240(e) and shall continue for the remainder of the existing 12-month eligibility period. However, at the time of the change in coverage, a family may choose to have the All KidsKidCare Share or Premium coverage retroactive to the first day of the first month following the last month of coverage under the private or employer sponsored insurance if the family refunds within 30 days after the Department's notice that the child's coverage has been changed to All KidsKidCare Health Plan any Rebate payment received for a month in which there was no private or employer based insurance coverage, notwithstanding Section 125.445(c).

- d) A child with significant health insurance may choose to change coverage from the All KidsKidCare Health Plan to All KidsKidCare Rebate without eligibility being reviewed by the Department if the family returns a Rebate form and there are no unpaid premiums owed to the Department. Coverage under All KidsKidCare Rebate shall be prospective from the effective date determined according to Section 125.240(e), following receipt by the Department of a completed Rebate Form and shall continue for the remainder of the existing 12-month eligibility period.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.265 Adding Eligible Adults to the Program and Changes in Participation**  
**(Repealed)**

- a) ~~Families may add eligible adults to the Program during the 12-month eligibility period if the family income meets the income levels as stated in Section 125.240. Coverage for the added eligible adult shall be prospective from the effective date determined according to Section 125.240(e) and may also include any prior coverage established pursuant to Section 125.240(f).~~
- b) ~~Premium amounts under the FamilyCare Health Plan and Rebates under FamilyCare Rebate will be adjusted to reflect adding or removing an eligible adult from the Program.~~
- e) ~~An eligible adult who would otherwise be terminated from FamilyCare Rebate because of losing private or employer sponsored health insurance may change coverage to the FamilyCare Health Plan if there is no unpaid Rebate overpayment. Coverage under the FamilyCare Health Plan shall be prospective from the effective date determined according to Section 125.240(e). However, at~~

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~~the time of the change in coverage, a family may choose to have the FamilyCare Share or Premium coverage retroactive to the first day of the first month following the last month of coverage under the private or employer sponsored insurance if the family refunds, within 30 days after the Department's notice that the person's coverage has been changed to FamilyCare Health Plan, any Rebate payment received for a month in which there was no private or employer based insurance coverage, except as described in Section 125.445(e).~~

- d) ~~An eligible adult with significant health insurance may change coverage to FamilyCare Rebate if the family returns a Rebate form and there are no unpaid premiums owed to the Department. Coverage under FamilyCare Rebate shall be prospective from the effective date determined according to Section 125.240(e), following receipt by the Department of a completed Rebate Form.~~

(Source: Repealed at 37 Ill. Reg. 10253, effective June 27, 2013)

SUBPART C: ALL KIDSKIDCARE/FAMILYCARE HEALTH PLAN**Section 125.300 Covered Services**

a) For children covered under the All KidsKidCare Health Plan, covered health care services shall be the same covered services for children as described at 89 Ill. Adm. Code 140, 77 Ill. Adm. Code 2090, and 59 Ill. Adm. Code 132, except as provided in Section 125.305, and subject to appropriation and any applicable cost sharing requirements defined in Section 125.310 and Section 125.320.

- b) ~~For eligible adults covered under the FamilyCare Health Plan, covered health care services shall be the same covered services for adults as described at 89 Ill. Adm. Code 140, 77 Ill. Adm. Code 2090, and 59 Ill. Adm. Code 132, except as provided at Section 125.305, and subject to appropriation and any applicable cost sharing requirements defined in Section 125.310 and Section 125.320.~~

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.305 Service Exclusions**

The following health care services will not be covered under the All KidsKidCare/FamilyCare Health Plan:

- a) Services provided only through a waiver approved under sectionSection 1915(c)

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of the Social Security Act ([42 USC 1396n\(c\)](#)).

- b) Abortion services.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.310 Copayments**

- a) ~~Effective July 1, 2012, copayments~~Copayments may be charged to the family by a health care professional whenever the service is performed in an office or home setting, except for visits scheduled for well-baby care, well-child care or age-appropriate immunizations. Copayments may also be charged to the family by hospitals, ~~for inpatient hospitalization once per inpatient admission~~ or outpatient encounter ~~(including the emergency room)~~. No copayment is permitted for visits to health care professionals or hospitals made solely for speech, occupational or physical therapy, audiology, radiology or laboratory services (including APL Group 2 procedures). Families with an enrolled individual who is an American Indian or Alaska Native shall not be charged copayments.
- b) ~~Effective July 1, 2012, copayment~~Copayment requirements are as follows, ~~subject to federal approval~~:
- 1) Practitioner office visit:
    - A) ~~All KidsKidCare/FamilyCare~~ Share copayment: ~~the nominal copayment amount as defined in federal regulations at 42 CFR 447.54, which, for dates of services beginning July 1, 2012 through March 31, 2013, is \$3.65. Beginning April 1, 2013, the nominal copayment amount is \$3.90. Specific copayment amounts are described and updated on the Department's Web site~~\$2 per visit.
    - B) ~~All KidsKidCare/FamilyCare~~ Premium Level 1 copayment: \$5 per visit.
  - 2) ~~Home health care visit~~:
    - A) ~~KidCare/FamilyCare~~ Share copayment: \$2 per visit.
    - B) ~~KidCare/FamilyCare~~ Premium copayment: \$5 per visit.

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23) Inpatient hospitalization:

- A) ~~All KidsKidCare/FamilyCare~~ Share copayment: a copayment amount as defined in federal regulations at 42 CFR 447, which, for dates of service beginning July 1, 2012 through March 31, 2012, is \$3.65 per admission. Beginning April 1, 2013, the nominal copayment amount is \$3.90 per day. Specific copayment amounts are described and updated annually on the Department's Web site.~~\$2 per admission.~~
- B) ~~All KidsKidCare/FamilyCare~~ Premium Level 1 copayment: \$5 per day admission.

34) Outpatient hospital encounter ~~(including the emergency room)~~:

- A) ~~All KidsKidCare/FamilyCare~~ Share copayment: the nominal copayment amount as defined in federal regulations at 42 CFR 447.54, which, for dates of service beginning July 1, 2012 through March 31, 2013, is \$3.65. Beginning April 1, 2013, the nominal copayment amount is \$3.90. Specific copayment amounts are described and updated annually on the Department's Web site.~~\$2 per visit.~~
- B) ~~All KidsKidCare/FamilyCare~~ Premium Level 1 copayment: \$5 per visit.

45) Prescription drugs:

- A) ~~All KidsKidCare/FamilyCare~~ Share copayment: \$2 for a 1-day to 30-day supply ~~of on both~~ generic drugs, including over-the-counter drugs and the nominal copayment amount as defined in federal regulations at 42 CFR 447.54, which, for dates of service beginning July 1, 2012 through March, 31, 2013 is \$3.65. Beginning April 1, 2013, the nominal copayment amount is \$3.90 for a 1-day to 30-day supply of brand name drugs. Specific copayment amounts are described and updated on the Department's Web site.
- B) ~~All KidsKidCare/FamilyCare~~ Premium Level 1 ~~copayment~~copayments: \$3 for a 1-day to 30-day supply ~~of on~~

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generic drugs or \$5 for 1-~~day~~ to 30-day supply ~~of~~ brand name drugs.

~~56)~~ Nonemergency visit to an emergency room:

A) ~~All Kids Share copayment: \$0 per visit~~~~KidCare/FamilyCare Share copayments: \$2 per visit.~~

B) ~~All Kids~~~~KidCare/FamilyCare~~ Premium Level 1 copayment: \$25 per visit.

~~6)~~ Emergency room visit:

~~A)~~ All Kids Share copayment: \$0 per visit.

~~B)~~ All Kids Premium Level 1 copayment: \$5 per visit.

c) The maximum out-of-pocket expense a family will incur for copayments during a 12-month eligibility period is \$100.

d) Once the family has satisfied the copayment cap, the family is responsible for submitting receipts, to the Department, documenting the payment of copayments. The Department may return partial documentation received on copayments to the family.

e) Upon the Department determining that the copayment cap has been satisfied, the following will occur:

1) A notice stating that the copayment cap has been satisfied, and the date satisfied, will be sent to the family.

~~2) A message that the copayment cap has been satisfied, and the date satisfied, will be available through the family's identification card.~~

~~23)~~ REV will be updated to reflect that the copayment cap has been reached.

f) Providers will be responsible for collecting copayments under the All Kids~~KidCare/FamilyCare~~ Health Plan.

g) Providers may elect not to charge copayments. If copayments are charged, the

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copayment must comply with the requirements in this Section.

- h) Providers shall be responsible for refunding to the family copayments they collect after the family has reached the copayment cap.
- i) The Department will not require providers to deliver services when copayments properly charged under the All KidsKidCare/FamilyCare Health Plan are not paid.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.320 Premium Requirements**

- a) Families with individuals enrolled in All KidsKidCare/FamilyCare Premium pursuant to Section 125.240(c) must pay the premiums established by this Section.
- b) The premium amounts are \$15 for one individual, \$25 for two individuals, \$30 for three individuals, \$35 for four individuals, and \$40 for five or more individuals.
- c) Premiums are billed by and payable to the Department, or its authorized agent, on a monthly basis.
- d) The premium due date will be 26 days after the fifth day of the calendar month preceding the month of coverage.
- e) The premium will not change during the eligibility period, unless the family adds or removes individuals from the coverage.
- f) No premiums shall be charged to families with an enrolled individual who is an American Indian or Alaska Native.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.330 Non-payment of Premium**

- a) All KidsKidCare/FamilyCare Health Plan participants will have a grace period through the end of the month following the coverage month to pay the premium.
- b) Failure to pay the full monthly premium by the last day of the grace period will

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result in termination of coverage.

- c) Partial premium payments will not be refunded.
- d) Collection action will be initiated by the Department to collect unpaid premiums.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.340 Provider Reimbursement**

- a) Providers under this Part shall be subject to approval by the Department to provide health care under the Illinois Public Aid Code.
- b) Provider participation under this Part shall be voluntary.
- c) Providers under this Part shall be reimbursed in accordance with the established rates of the Department or other appropriate State agency.
- d) In addition to reimbursements received from the Department, providers may retain copayments defined in Section 125.310.
- e) Providers under this Part shall be prohibited from billing families covered under the ~~All KidsKidCare/FamilyCare~~ Health Plan any difference between the charge amount and the amount paid by the Department, except for copayments as specified in Section 125.310.
- f) Providers shall be responsible for refunding to the family copayments collected in excess of the amounts permitted by this Part.
- g) Effective July 1, 2012, in each instance in which a copayment is payable, the Department will reduce the amount payable to the provider by the respective amount of the required payment.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

SUBPART D: ~~ALL KIDSKIDCARE/FAMILYCARE~~ REBATE**Section 125.400 Minimum Coverage Requirements**

For an eligible individual to participate in ~~All KidsKidCare/FamilyCare~~ Rebate, the eligible

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individual must be covered by an insurance plan that offers comprehensive major medical coverage providing benefits for physician services and hospital inpatient services.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.420 Coverage Verification Process**

- a) All applications for participation in [All KidsKidCare/FamilyCare](#) Rebate must be accompanied by the Department's Insurance Rebate Form.
- b) Verification of insurance coverage for the previous coverage period will be required at the annual renewal of [All KidsKidCare/FamilyCare](#) Rebate.
- c) The Department, or its authorized agent, may verify insurance coverage for participants under [All KidsKidCare/FamilyCare](#) Rebate.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.430 Provision of Policyholder's Social Security Number**

For an eligible individual to participate in [All KidsKidCare/FamilyCare](#) Rebate, the policyholder's valid Social Security Number must be provided.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.440 [All KidsKidCare/FamilyCare Insurance](#) Rebate**

- a) The Rebate will be paid to the individual policyholder insuring the individual.
- b) The Department will issue Rebates on a monthly basis.
- c) The total dollar amount of the Rebate paid by the Department per individual per month shall be the lesser of:
  - 1) The maximum monthly amount set by the Department calculated in accordance with the restrictions in 215 ILCS 106/25 and available appropriations, or
  - 2) The policyholder's monthly portion of the premium paid for coverage of individuals enrolled under [All KidsKidCare/FamilyCare](#) Rebate.

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- d) The Department shall set the amount of the Rebate, described in subsection (c) of this Section, prospectively.
- e) To be eligible for payment, a Rebate must equal at least one dollar.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

**Section 125.445 Rebate Overpayments**

- a) For purposes of this Part, a Rebate overpayment occurs in any of the following circumstances:
  - 1) the monthly Rebate paid was higher than the policyholder's portion of the premium for the individuals enrolled in All KidsKidCare/FamilyCare Rebate;
  - 2) the monthly Rebate paid per individual was higher than the maximum monthly amount set by the Department pursuant to Section 125.440(c)(1);
  - 3) the Rebate was paid for an individual who was incorrectly enrolled in All KidsKidCare/FamilyCare Rebate due to inaccurate or untruthful information provided on the application;
  - 4) the Rebate was paid for a period during which the individual was not covered by private or employer-based insurance meeting the requirements of Section 125.400; or
  - 5) the Rebate was paid for an eligible adult for whom an increase in income was not reported within 10ten days after the change and the family's income exceeded the upper limit set at Section 125.200(c)(2).
- b) Collection action will be initiated by the Department to collect Rebate overpayments.
- c) In cases in whichwhere the family notified the Department of the loss of insurance of any enrolled individual or the increase of income with respect to an eligible adult within 10ten days after the change but past the date when the Department was able to stop issuance or adjust the amount of the next Rebate, the relevant portion of the Rebate is not an overpayment.

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- d) In cases in which~~where~~ an individual is covered by private or employer-based insurance (regardless of whether the coverage meets the requirements of Section 125.400) and, due to Department error, Department of Human Services error or inaccurate information from an employer or other third party, an individual is enrolled in Rebate that should not have been or a Rebate payment is higher than it would have been if properly calculated based on accurate information, no overpayment occurs, provided the amount sent in any month does not exceed the maximum monthly amount set by the Department pursuant to Section 125.440(c)(1).

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

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- 1) Heading of the Part: Medical Payment
- 2) Code Citation: 89 Ill. Adm. Code 140
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
140.2	Amendment
140.3	Amendment
140.5	Amendment
140.11	Amendment
140.12	Amendment
140.13	Amendment
140.14	Amendment
140.15	Amendment
140.16	Amendment
140.18	Amendment
140.19	Amendment
140.20	Amendment
140.30	Amendment
140.32	Amendment
140.44	Amendment
140.45	New Section
140.80	Amendment
140.402	Amendment
140.405	New Section
140.413	Amendment
140.414	Amendment
140.417	Amendment
140.420	Amendment
140.425	Amendment
140.428	Amendment
140.440	Amendment
140.441	Amendment
140.442	Amendment
140.443	Amendment
140.445	Amendment
140.449	Amendment
140.457	Amendment
140.458	Amendment
140.469	Amendment

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140.470	Amendment
140.471	Amendment
140.472	Amendment
140.473	Amendment
140.474	Amendment
140.477	Amendment
140.498	Amendment
140.523	Amendment
140.TABLE D	Amendment
140.TABLE F	Repeal

- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and P.A. 97-0689
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: Yes, February 8, 2013; 37 Ill. Reg. 1390 and April 26, 2013; 37 Ill. Reg. 4429 (140.402)
- 10) Has JCAR issued a Statement of Objection to this Rulemaking? No
- 11) Differences between Proposal and Final Version: The following changes have been made: An Effective date of July 1, 2012 has been added to provisions implemented by emergency rule on that date.

In Section 140.14(e)(5), after "cousin or" add "other".

In Section 140.15(e), after the word "information:" replaced language to read as follows: " (i) has actual knowledge of the information, (ii) acts in deliberate ignorance of the truth or falsity of the information, or (iii) acts in reckless disregard of the truth or falsity of the information."

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In Section 140.402(a) changed "2013" to "2012"; deleted "may" and added "shall"; and after "42 CFR 447.54." added the following sentence; "For Dates of services beginning July 1, 2012 through March 31, 2013 the nominal copayment amount is \$3.65. Beginning with dates of services on April 1, 2013, the nominal copayment amount is \$3.90."

In Section 140.402(a)(3) after the word "(RHC)" added ", but excluding behavioral services provided by these facilities. For dates of service beginning July 1, 2013, copayments for behavioral health services provided by these facilities are no longer excluded."

In Section 140.402(e) added "140.402(e)(11)" to read as follows: "Preventive services as described in Section 4106(b) of the Affordable Care Act."

In Section 140.413(a)(3) added; "Effective October 1, 2012"; strike "Surgery" and add "surgery"; and strike the dash, add "is" and lowercase "Covered".

- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? Yes, July 20, 2012; 36 Ill. Reg. 11329 and April 12, 2013; 37 Ill. Reg. 5058
- 14) Are there any other proposed rulemakings pending on this Part? Yes

<u>Sections</u>	<u>Proposed Action</u>	<u>Illinois Register Citation</u>
140.491	Amendment	36 Ill. Reg. 18105; December 28, 2012
140.24	Amendment	37 Ill. Reg. 3362; March 22, 2013
140.28	Amendment	37 Ill. Reg. 3362; March 22, 2013
140.481	Amendment	37 Ill. Reg. 5243; April 26, 2013
140.55	Amendment	37 Ill. Reg. 7078; May 24, 2013

- 15) Summary and Purpose of Rulemaking: These amendments are to comply with the SMART Act, P.A. 97-689 and implement changes, improvements, and efficiencies to enhance Medicaid program integrity to prevent client and provider fraud. These rules also impose controls on use of Medicaid services to prevent over-use or waste; expand cost-sharing by clients; and makes rate adjustments and reductions to update rates or reflect budget realities.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

The full text of the Adopted Amendments begins on the next page:

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## SUBCHAPTER d: MEDICAL PROGRAMS

## PART 140

## MEDICAL PAYMENT

## SUBPART A: GENERAL PROVISIONS

## Section

- 140.1 Incorporation By Reference
- 140.2 Medical Assistance Programs
- 140.3 Covered Services Under Medical Assistance Programs
- 140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
- 140.5 Covered Medical Services Under General Assistance
- 140.6 Medical Services Not Covered
- 140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
- 140.8 Medical Assistance For Qualified Severely Impaired Individuals
- 140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
- 140.10 Medical Assistance Provided to Persons Confined or Detained by the Criminal Justice System

## SUBPART B: MEDICAL PROVIDER PARTICIPATION

## Section

- 140.11 Enrollment Conditions for Medical Providers
- 140.12 Participation Requirements for Medical Providers
- 140.13 Definitions
- 140.14 Denial of Application to Participate in the Medical Assistance Program
- 140.15 Suspension and Denial of Payment, Recovery of Money and Penalties
- 140.16 Termination, ~~or~~ Suspension or Exclusion of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.18 Effect of Termination, Suspension, Exclusion or Revocation on Persons

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- Associated with Vendor
- 140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension, Exclusion or Barring
- 140.20 Submittal of Claims
- 140.21 Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits
- 140.22 Magnetic Tape Billings (Repealed)
- 140.23 Payment of Claims
- 140.24 Payment Procedures
- 140.25 Overpayment or Underpayment of Claims
- 140.26 Payment to Factors Prohibited
- 140.27 Assignment of Vendor Payments
- 140.28 Record Requirements for Medical Providers
- 140.30 Audits
- 140.31 Emergency Services Audits
- 140.32 Prohibition on Participation, and Special Permission for Participation
- 140.33 Publication of List of Sanctioned Entities
- 140.35 False Reporting and Other Fraudulent Activities
- 140.40 Prior Approval for Medical Services or Items
- 140.41 Prior Approval in Cases of Emergency
- 140.42 Limitation on Prior Approval
- 140.43 Post Approval for Items or Services When Prior Approval Cannot Be Obtained
- 140.44 Withholding of Payments Due to Fraud or Misrepresentation
- 140.45 Withholding of Payments Upon Provider Audit, Quality of Care Review, Credible Allegation of Fraud or Failure to Cooperate
- 140.55 Recipient Eligibility Verification (REV) System
- 140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments
- 140.72 Drug Manual (Recodified)
- 140.73 Drug Manual Updates (Recodified)

## SUBPART C: PROVIDER ASSESSMENTS

- Section
- 140.80 Hospital Provider Fund
- 140.82 Developmentally Disabled Care Provider Fund
- 140.84 Long Term Care Provider Fund
- 140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust

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	Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
140.95	Hospital Services Trust Fund
140.96	General Requirements (Recodified)
140.97	Special Requirements (Recodified)
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140.99	Hospital Services Not Covered (Recodified)
140.100	Limitation On Hospital Services (Recodified)
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140.102	Heart Transplants (Recodified)
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140.104	Bone Marrow Transplants (Recodified)
140.110	Disproportionate Share Hospital Adjustments (Recodified)
140.116	Payment for Inpatient Services for GA (Recodified)
140.117	Hospital Outpatient and Clinic Services (Recodified)
140.200	Payment for Hospital Services During Fiscal Year 1982 (Recodified)
140.201	Payment for Hospital Services After June 30, 1982 (Repealed)
140.202	Payment for Hospital Services During Fiscal Year 1983 (Recodified)
140.203	Limits on Length of Stay by Diagnosis (Recodified)
140.300	Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Recodified)
140.350	Copayments (Recodified)
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140.366	Restructuring Adjustment (Recodified)
140.367	Inflation Adjustment (Recodified)
140.368	Volume Adjustment (Repealed)
140.369	Groupings (Recodified)
140.370	Rate Calculation (Recodified)
140.371	Payment (Recodified)
140.372	Review Procedure (Recodified)
140.373	Utilization (Repealed)
140.374	Alternatives (Recodified)
140.375	Exemptions (Recodified)
140.376	Utilization, Case-Mix and Discretionary Funds (Repealed)
140.390	Subacute Alcoholism and Substance Abuse Services (Recodified)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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- 140.391 Definitions (Recodified)
- 140.392 Types of Subacute Alcoholism and Substance Abuse Services (Recodified)
- 140.394 Payment for Subacute Alcoholism and Substance Abuse Services (Recodified)
- 140.396 Rate Appeals for Subacute Alcoholism and Substance Abuse Services (Recodified)
- 140.398 Hearings (Recodified)

## SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

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- 140.400 Payment to Practitioners
- 140.402 Copayments for Noninstitutional Medical Services
- 140.403 Telehealth Services
- 140.405 ~~Non-Institutional Rate Reductions Senior Care Pharmaceutical Benefit (Repealed)~~
- 140.410 Physicians' Services
- 140.411 Covered Services By Physicians
- 140.412 Services Not Covered By Physicians
- 140.413 Limitation on Physician Services
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- 140.416 Optometric Services and Materials
- 140.417 Limitations on Optometric Services
- 140.418 Department of Corrections Laboratory
- 140.420 Dental Services
- 140.421 Limitations on Dental Services
- 140.422 Requirements for Prescriptions and Dispensing Items of Pharmacy Items – Dentists (Repealed)
- 140.425 Podiatry Services
- 140.426 Limitations on Podiatry Services
- 140.427 Requirement for Prescriptions and Dispensing of Pharmacy Items – Podiatry (Repealed)
- 140.428 Chiropractic Services
- 140.429 Limitations on Chiropractic Services (Repealed)
- 140.430 Independent Clinical Laboratory Services
- 140.431 Services Not Covered by Independent Clinical Laboratories
- 140.432 Limitations on Independent Clinical Laboratory Services
- 140.433 Payment for Clinical Laboratory Services
- 140.434 Record Requirements for Independent Clinical Laboratories
- 140.435 Advanced Practice Nurse Services
- 140.436 Limitations on Advanced Practice Nurse Services

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- 140.440 Pharmacy Services
- 140.441 Pharmacy Services Not Covered
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- 140.451 Prospective Drug Review and Patient Counseling
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- 140.471 Description of Home Health Care Services
- 140.472 Types of Home Health Care Services
- 140.473 Prior Approval for Home Health Care Services
- 140.474 Payment for Home Health Care Services
- 140.475 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
- 140.476 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices for Which Payment Will Not Be Made
- 140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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- 140.478 Prior Approval for Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
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- 140.488 Periodicity Schedules, Immunizations and Diagnostic Laboratory Procedures
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## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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## Section

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## SUBPART K: MANDATORY MCO ENROLLMENT

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140.TABLE K	Services Qualifying for 10% Add-On (Repealed)
140.TABLE L	Services Qualifying for 10% Add-On to Surgical Incentive Add-On (Repealed)
140.TABLE M	Enhanced Rates for Maternal and Child Health Provider Services

AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; preemptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; preemptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; preemptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; preemptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a

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maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg. 7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940

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thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990;

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amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; Notice of Corrections to Adopted Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment

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suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective

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September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25 Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill. Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective

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November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; emergency amendment at 28 Ill. Reg. 6622, effective April 19, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7081, effective May 3, 2004; emergency amendment at 28 Ill. Reg. 8108, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9640, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10135, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11161, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12198, effective August 11, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13775, effective October 1, 2004; amended at 28 Ill. Reg. 14804, effective October 27, 2004; amended at 28 Ill. Reg. 15513, effective November 24, 2004; amended at 29 Ill. Reg. 831, effective January 1, 2005; amended at 29 Ill. Reg. 6945, effective May 1, 2005; emergency amendment at 29 Ill. Reg. 8509, effective June 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12534, effective August 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 14957, effective September 30, 2005; emergency amendment at 29 Ill. Reg. 15064, effective October 1, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 15985, effective October 5, 2005, for the remainder of the maximum 150 days; emergency amendment at 29 Ill. Reg. 15610, effective October 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 16515, effective October 5, 2005, for a maximum of 150 days; amended at 30 Ill. Reg. 349, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 573, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 796, effective January 1, 2006; amended at 30 Ill. Reg. 2802, effective February 24, 2006; amended at 30 Ill. Reg. 10370, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 12376, effective July 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 13909, effective August 2, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 14280, effective August 18, 2006; expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 17970, effective November 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18648, effective November 27, 2006; emergency amendment at 30 Ill. Reg. 19400, effective December 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 388, effective December 29, 2006; emergency amendment at 31 Ill. Reg. 1580, effective January 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 2413, effective January 19, 2007; amended at 31 Ill. Reg. 5561, effective March 30, 2007; amended at 31 Ill. Reg. 6930, effective April 29, 2007; amended at 31 Ill. Reg. 8485, effective May 30, 2007; emergency amendment at 31 Ill. Reg. 10115, effective June 30, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 14749, effective October 22, 2007; emergency amendment at 32 Ill. Reg. 383, effective January 1, 2008, for a maximum of 150 days; preemptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; preemptory amendment suspended at 32 Ill. Reg. 8449, effective May 21, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 32 Ill. Reg. 18323, effective November 12, 2008; preemptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days;

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emergency expired April 10, 2009; preemptory amendment repealed at 33 Ill. Reg. 6667, effective April 29, 2009; amended at 32 Ill. Reg. 7727, effective May 5, 2008; emergency amendment at 32 Ill. Reg. 10480, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 32 Ill. Reg. 17133, effective October 15, 2008; amended at 33 Ill. Reg. 209, effective December 29, 2008; amended at 33 Ill. Reg. 9048, effective June 15, 2009; emergency amendment at 33 Ill. Reg. 10800, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 11287, effective July 14, 2009; amended at 33 Ill. Reg. 11938, effective August 17, 2009; amended at 33 Ill. Reg. 12227, effective October 1, 2009; emergency amendment at 33 Ill. Reg. 14324, effective October 1, 2009, for a maximum of 150 days; emergency expired February 27, 2010; amended at 33 Ill. Reg. 16573, effective November 16, 2009; amended at 34 Ill. Reg. 516, effective January 1, 2010; amended at 34 Ill. Reg. 903, effective January 29, 2010; amended at 34 Ill. Reg. 3761, effective March 14, 2010; amended at 34 Ill. Reg. 5215, effective March 25, 2010; amended at 34 Ill. Reg. 19517, effective December 6, 2010; amended at 35 Ill. Reg. 394, effective December 27, 2010; amended at 35 Ill. Reg. 7648, effective May 1, 2011; amended at 35 Ill. Reg. 7962, effective May 1, 2011; amended at 35 Ill. Reg. 10000, effective June 15, 2011; amended at 35 Ill. Reg. 12909, effective July 25, 2011; amended at 36 Ill. Reg. 2271, effective February 1, 2012; amended at 36 Ill. Reg. 7010, effective April 27, 2012; amended at 36 Ill. Reg. 7545, effective May 7, 2012; amended at 36 Ill. Reg. 9113, effective June 11, 2012; emergency amendment at 36 Ill. Reg. 11329, effective July 1, 2012 through June 30, 2013; emergency amendment to Section 140.442(e)(4) suspended at 36 Ill. Reg. 13736, effective August 15, 2012; suspension withdrawn from Section 140.442(e)(4) at 36 Ill. Reg. 14529, September 11, 2012; emergency amendment in response to Joint Committee on Administrative Rules action on Section 140.442(e)(4) at 36 Ill. Reg. 14820, effective September 21, 2012 through June 30, 2013; emergency amendment to Section 140.491 suspended at 36 Ill. Reg. 13738, effective August 15, 2012; suspension withdrawn by the Joint Committee on Administrative Rules from Section 140.491 at 37 Ill. Reg. 890, January 8, 2013; emergency amendment in response to Joint Committee on Administrative Rules action on Section 140.491 at 37 Ill. Reg. 1330, effective January 15, 2013 through June 30, 2013; amended at 36 Ill. Reg. 15361, effective October 15, 2012; emergency amendment at 37 Ill. Reg. 253, effective January 1, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 846, effective January 9, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 1774, effective January 28, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 2348, effective February 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 3831, effective March 13, 2013; emergency amendment at 37 Ill. Reg. 5058, effective April 1, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 5170, effective April 8, 2013 through June 30, 2013; amended at 37 Ill. Reg. 6196, effective April 29, 2013; amended at 37 Ill. Reg. 7985, effective May 29, 2013; amended at 37 Ill. Reg. 10282, effective June 27, 2013.

## SUBPART A: GENERAL PROVISIONS

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**Section 140.2 Medical Assistance Programs**

- a) Under the Medical Assistance Programs, the Department pays participating providers for necessary medical services, specified in Section 140.3 through 140.7 for:
- 1) persons eligible for financial assistance under the Aid to the Aged, Blind or Disabled-State Supplemental Payment (AABD-SSP) and Temporary Assistance to Needy Families (TANF) programs (Medicaid-MAG);
  - 2) persons who would be eligible for financial assistance but who have resources in excess of the Department's eligibility standards and who have incurred medical expenses greater than the difference between their income and the Department's standards (Medicaid-MANG);
  - ~~3) persons receiving financial assistance under the General Assistance (GA) program, either State Transitional Assistance or State Family and Children Assistance (GA-Medical);~~
  - ~~3)4) individuals under age 18 who do not qualify for TANF/TANF-MANG and infants under age one year (see Section 140.7);~~
  - ~~4)5) pregnant women who would not be eligible for TANF/TANF-MANG if the child were born and who do not qualify as mandatory categorically needy (see Section 140.9);~~
  - ~~5)6) persons who are eligible for Title IV-E adoption assistance/foster care assistance from another State and who are living in Illinois;~~
  - ~~6)7) noncitizens who have an emergency medical condition (see 89 Ill. Adm. Code 120.310); however, payment is not included for care and services related to an organ transplant procedure;~~
  - ~~7)8) persons eligible for medical assistance under the Aid to the Aged, Blind or Disabled (AABD) program who reside in specified Supportive Living Facilities (SLFs), as described at 89 Ill. Adm. Code 146, Subpart B; and~~

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~~8)9)~~ persons eligible for FamilyCare as described in 89 Ill. Adm. Code 120.32 and 120.34 and 89 Ill. Adm. Code 118.600, Subpart F.

- b) "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity or impairment.
- c) The Department may impose prior approval requirements, as specified by rule, to determine whether the medical care is necessary and eligible for payment from the Department in individual situations. Such requirements shall be based on recommendations of technical and professional staff and advisory committees.
- d) When recipients are entitled to Medicare benefits, the Department shall assume responsibility for their deductible and coinsurance obligations, unless the recipients have income and/or resources available to meet these needs. The total payment to a provider from both Medicare and the Department shall not exceed either the amount that Medicare determines to be a reasonable charge or the Department standard for the services provided, whichever is applicable.
- e) The Department shall pay for services and items not allowed by Medicare only if they are provided in accordance with Department policy for recipients not entitled to Medicare benefits.
- f) The Department may contract with qualified practitioners, hospitals and all other dispensers of medical services for the provision and reimbursement of any and all medical care or services as specified in the contract on a prepaid capitation basis (i.e., payment of a fixed amount per enrollee made in advance of the service); volume purchase basis (i.e., purchase of a volume of goods or services for a price specified in the contract); ambulatory visit basis (i.e., one comprehensive payment for each visit regardless of the services provided during that visit) or per discharge basis (i.e., one comprehensive payment per discharge regardless of the services provided during the stay). Such contracts shall be based either on formally solicited competitive bid proposals or individually negotiated rates with providers willing to enter into special contractual arrangements with the State.
- g) The Department may require that recipients of medical assistance under any of the Department's programs exercise their freedom of choice by choosing to receive medical care under the traditional fee for service system or through a prepaid capitation plan or under one of the other alternative contractual arrangements described in subsection (f) of this Section. The categories of recipients who may

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choose or be assigned to an alternative plan will be specified in the contract. Recipients required to make such a choice will be notified in writing by the Department. If a recipient does not choose to exercise his/her freedom of choice, the Department may assign that recipient to a prepaid plan. Under such a plan, recipients would obtain certain medical services or supplies from a single source or limited source. The Department will notify recipients in writing if they are assigned to a prepaid plan. Recipients enrolled in or assigned to a prepaid plan will receive written notification advising them of the services which they will receive from the plan. Covered services not provided by the plan will be reimbursed by the Department on a fee for service basis. Recipients will receive a medical eligibility card, which will apply to such services.

- h) The Department may enter into contracts for the provision of medical care on a prepaid capitation basis from a Health Maintenance Organization (HMO) whereby the recipient who chooses to receive medical care through an HMO must stay in the HMO for a certain period of time, not to exceed six months (the enrollment period). Upon written notice, the recipient may choose to disenroll from such an HMO at any time within the first month of each enrollment period. The Department will send the recipient a notice at least 30 days prior to the end of the enrollment period, which gives the recipient a specified period of time in which to inform the Department if the recipient does not wish to re-enroll in the HMO for a new enrollment period. The recipient may then disenroll at the end of the enrollment period only if the recipient responds to the notice and indicates in writing a choice to disenroll. Failure to respond to the notice will result in automatic re-enrollment for a new enrollment period. Recipients shall also be allowed to disenroll at any time for cause.
- i) The Department may enter into contracts for the provision of medical care on a prepaid capitation basis from a Health Maintenance Organization whereby the recipient who chooses to receive medical care through an HMO may choose to disenroll at any time, upon written notice.
- j) The Department shall pay for services under the Maternal and Child Health Program, a primary health care program for pregnant women and children (see Subpart G).
- k) Services covered for persons who are confined or detained as described in 89 Ill. Adm. Code 120.318(b) shall be limited as described in Section 140.10.

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(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.3 Covered Services Under Medical Assistance Programs**

- a) As described in this Section, medical services shall be covered for:
- 1) recipients of financial assistance under the AABD (Aid to the Aged, Blind or Disabled), TANF (Temporary Assistance to Needy Families), or Refugee/Entrant/Repatriate programs;
  - 2) recipients of medical assistance only under the AABD program (AABD-MANG);
  - 3) recipients of medical assistance only under the TANF program (TANF-MANG);
  - 4) individuals under age 18 not eligible for TANF (see Section 140.7), pregnant women who would be eligible if the child were born and pregnant women and children under age eight who do not qualify as mandatory categorically needy (see Section 140.9);
  - 5) disabled persons under age 21 who may qualify for Medicaid or in-home care under the Illinois Home and Community-Based Services Waiver for Medically Fragile Technology Dependent Children; and
  - ~~6) recipients eligible under the State Transitional Assistance Program who are determined by the Department to be disabled; and~~
  - ~~6)7) Individuals 19 years of age or older eligible under the KidCare Parent Coverage Waiver as described at 89 Ill. Adm. Code 120.32 except for:~~
    - A) Services provided only through a waiver approved under section 1915(c) of the Social Security Act; and
    - B) Termination of pregnancy.
- b) The following medical services shall be covered for recipients under age 21 who are included under subsection (a):

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- 1) Inpatient hospital services;
- 2) Hospital outpatient and clinic services;
- 3) Hospital emergency room visits. The visit must be for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries which might result in disability or death if there is not immediate treatment;
- 4) Encounter rate clinic visits;
- 5) Physician services;
- 6) Pharmacy services;
- 7) Home health agency visits;
- 8) Laboratory and x-ray services;
- 9) Group care services;
- 10) Family planning services and supplies;
- 11) Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
- 12) Transportation to secure medical services;
- 13) EPSDT services pursuant to Section 140.485;
- 14) Dental services;
- 15) Chiropractic services;
- 16) Podiatric services;
- 17) Optical services and supplies;

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- 18) Subacute alcoholism and substance abuse services pursuant to Sections 140.390 through 140.396;
- 19) Hospice services;
- 20) Nursing care pursuant to Section 140.472;
- 21) Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting pursuant to 89 Ill. Adm. Code 146, Subpart D; and
- 22) Telehealth services pursuant to Section 140.403.

c) Effective July 1, 2012, the ~~The~~ following medical services shall be covered for recipients age 21 or over who are included under subsection (a):

- 1) Inpatient hospital services;
- 2) Hospital outpatient and clinic services;
- 3) Hospital emergency room visits. The visit must be for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries which might result in disability or death if there is not immediate treatment;
- 4) Encounter rate clinic visits;
- 5) Physician services;
- 6) Pharmacy services;
- 7) Home health agency visits;
- 8) Laboratory and x-ray services;
- 9) Group care services;
- 10) Family planning services and supplies;

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- 11) Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
- 12) Transportation to secure medical services;
- 13) Subacute alcoholism and substance abuse services pursuant to Sections 140.390 through 140.396;
- 14) Hospice services;
- 15) Dental services, pursuant to Section 140.420;
- ~~16) Chiropractic services;~~
- 16)17) Podiatric services, pursuant to Section 140.425 for individuals with a diagnosis of diabetes;
- 17)18) Optical services and supplies; and
- 18)19) Telehealth services pursuant to Section 140.403.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.5 Covered Medical Services Under General Assistance**

This program is no longer in effect as of July 1, 2012.

- a) ~~The following medical services shall be covered for recipients of financial assistance under General Assistance for both the State Transitional Assistance Program and the State Family and Children Assistance Program:~~
  - ~~1) Encounter rate clinic visits;~~
  - ~~2) Physician services;~~
  - ~~3) Vital pharmacy services (items necessary for life maintenance or to avoid life threatening situations);~~
  - ~~4) Vital medical supplies and equipment;~~

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- ~~5) Group care services, subject to prior approval;~~
  - ~~6) Family planning services;~~
  - ~~7) Laboratory and x-ray services;~~
  - ~~8) Transportation to secure medical services;~~
  - ~~9) Prostheses, orthoses (only when essential for employment or expediting hospital discharge);~~
  - ~~10) Home health agency visits (only on a prior approval basis when the medical condition is documented by the physician as terminal);~~
  - ~~11) Hospice services;~~
  - ~~12) Dental services;~~
  - ~~13) Chiropractic services;~~
  - ~~14) Podiatric services; and~~
  - ~~15) Optical services and supplies.~~
- b) ~~The following medical services shall be covered for recipients of financial assistance under General Assistance only for the State Family and Children Assistance Program, not the State Transitional Assistance Program, in addition to the services covered under subsection (a) above:~~
- ~~1) Inpatient hospital services. (Physical rehabilitation services and psychiatric services are not covered for General Assistance recipients age 18 or over);~~
  - ~~2) Hospital outpatient and clinic services for surgical procedures, renal dialysis or cancer therapy; and~~
  - ~~3) Hospital emergency room visits. The visit must be for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or~~

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~~injuries which might result in disability or death if there is not immediate treatment.~~

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

## SUBPART B: MEDICAL PROVIDER PARTICIPATION

**Section 140.11 Enrollment Conditions for Medical Providers**

- a) In order to enroll for participation, providers shall:
- 1) Hold a valid, appropriate license where State law requires licensure of medical practitioners, agencies, institutions and other medical vendors;
  - 2) Be certified for participation in the Title XVIII Medicare program where federal or State rules and regulations require such certification for Title XIX participation;
  - 3) Be certified for Title XIX when federal or State rules and regulations so require;
  - 4) Provide enrollment information to the Department in the prescribed format, and notify the Department, in writing, immediately whenever there is a change in any such information which the provider has previously submitted;
  - 5) Provide disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business, enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to public aid recipients; and
  - 6) Have a written provider agreement on file with the Department.
- b) Approval of a corporate entity such as a pharmacy, laboratory, durable medical equipment and supplies provider, medical transportation provider, nursing home or renal satellite facility, as a participant in the Medical Assistance Program, applies only to the entity's existing ownership, corporate structure and location; therefore, participation approval is not transferable.

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- c) Except for children's hospitals described at 89 Ill. Adm. Code 149.50(c)(3), hospitals providing inpatient care that are certified under a single Medicare number shall be enrolled as an individual entity in the Medical Assistance Program. A children's hospital must be separately enrolled from the general care hospital with which it is affiliated.
- d) Upon notification from the Illinois Department of Public Health of a change of ownership, the Department shall notify the prospective buyer of its obligation under Section 140.12(l) to assume liability for repayment to the Department for overpayments made to the current owner or operator. Such notification shall inform the prospective buyer of all outstanding known liabilities due to the Department by the facility and of any known pending Department actions against the facility that may result in further liability. For long term care providers, when there is a change of ownership of a facility or a facility is leased to a new operator, the provider agreement shall be automatically assigned to the new owner or lessee. Such assigned agreement shall be subject to all conditions under which it was originally issued, including, but not limited to, any existing plans of correction, all requirements of participation as set forth in Section 140.12 or additional requirements imposed by the Department.
- e) For purposes of administrative efficiency, the Department may periodically require classes of providers to re-enroll in the Medical Assistance Program. Under such re-enrollments, the Department shall request classes of providers to submit updated enrollment information. Failure of a provider to submit such information within the requested time frames will result in the dis-enrollment of the provider from the Program. Such dis-enrollment shall have no effect on the future eligibility of the provider to participate in the Program and is intended only for purposes of the Department's efficient administration of the Program. A dis-enrolled provider may reapply to the Program and all such re-applications must meet the requirements for enrollment.
- f) For purposes of this Section, a vendor whose investor ownership has changed by 50 percent or more from the date the vendor was initially approved for enrollment in the Medical Assistance Program shall be required to submit a new application for enrollment in the Medical Assistance Program. All such applications must meet the requirements for enrollment.

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- g) Anything in this Subpart B to the contrary notwithstanding, enrollment of a ~~non-emergency transportation~~ vendor is subject to a provisional period and, as defined in Section 140.13, shall be conditional for one year unless limited by the Department. During the period of conditional enrollment, 180 days, during which time the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the Medical Assistance Program without cause. Upon termination of a ~~non-emergency transportation~~ vendor under this subsection (g), the following individuals shall be barred from participation in the Medical Assistance Program:
- 1) individuals with management responsibility;
  - 2) all owners or partners in a partnership;
  - 3) all officers of a corporation or individuals owning, directly or indirectly, five percent or more of the shares of stock or other evidence of ownership in a corporation; or
  - 4) an owner of a sole proprietorship.
- h) Unless otherwise specified, the termination~~Termination~~ of eligibility or vendor disenrollment, as described in subsection (g) of this Section, and resulting barmments are not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.12 Participation Requirements for Medical Providers**

The provider shall agree to:

- a) Verify eligibility of recipients prior to providing each service;
- b) Allow recipients the choice of accepting or rejecting medical or surgical care or treatment;
- c) Provide supplies and services in full compliance with all applicable provisions of State and federal laws and regulations pertaining to nondiscrimination and equal employment opportunity including but not limited to:

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- 1) Full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin;
  - 2) Full compliance with Section 504 of the Rehabilitation Act of 1973 and 45 CFR 84, which prohibit discrimination on the basis of handicap; and
  - 3) Without discrimination on the basis of religious belief, political affiliation, sex, age or disability;
- d) Comply with the requirements of applicable federal and State laws and not engage in practices prohibited by such laws;
  - e) Provide, and upon demand present documentation of, education of employees, contractors and agents regarding the federal False Claims Act (31 USC 3729-3733) that complies with all requirements of 42 USC 1396a(a)(68). Providers subject to this requirement include a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, that receives or makes payments totaling at least \$5 million annually;
  - f) Hold confidential, and use for authorized program purposes only, all Medical Assistance information regarding recipients;
  - g) Furnish to the Department, in the form and manner requested by it, any information it requests regarding payments for providing goods or services, or in connection with the rendering of goods or services or supplies to recipients by the provider, his agent, employer or employee;
  - h) Make charges for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges and in the same quality and mode of delivery as are provided to the general public;
  - i) Accept as payment in full the amounts established by the Department.
    - 1) If a provider accepts an individual eligible for medical assistance from the Department as a Medicaid recipient, such provider shall not bill, demand or otherwise seek reimbursement from that individual or from a financially

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responsible relative or representative of the individual for any service for which reimbursement would have been available from the Department if the provider had timely and properly billed the Department. For purposes of this subsection, "accepts" shall be deemed to include:

- A) an affirmative representation to an individual that payment for services will be sought from the Department;
  - B) an individual presents the provider with his or her medical card and the provider does not indicate that other payment arrangements will be necessary; or
  - C) billing the Department for the covered medical service provided an eligible individual.
- 2) If an eligible individual is entitled to medical assistance with respect to a service for which a third party is liable for payment, the provider furnishing the service may not seek to collect from the individual payment for that service if the total liability of the third party for that service is at least equal to the amount payable for that service by the Department.
- j) Accept assignment of Medicare benefits for public aid recipients eligible for Medicare, when payment for services to such persons is sought from the Department;
  - k) Complete an MCH (Maternal and Child Health) Primary Care Provider Agreement in order to participate in the Maternal and Child Health Program (see Section 140.924(a)(1)(D)); and
  - l) In the case of long term care providers, assume liability for repayment to the Department of any overpayment made to a facility regardless of whether the overpayment was incurred by a current owner or operator or by a previous owner or operator. Liability of current and previous providers to the Department shall be joint and several. Recoveries by the Department under this Section may be made pursuant to Sections 140.15 and 140.25. A current or previous owner or lessee may request from the Department a list of all known outstanding liabilities due the Department by the facility and of any known pending Department actions against a facility that may result in further liability. For purposes of this Section, "overpayment" shall include, but not be limited to:

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- 1) Amounts established by final administrative decisions pursuant to 89 Ill. Adm. Code 104;
- 2) Overpayments resulting from advance C-13 payments made pursuant to Section 140.71;
- 3) Liabilities resulting from nonpayment or delinquent payment of assessments pursuant to Sections 140.82, 140.84 and 140.94; and
- 4) Amounts identified during past, pending or future audits that pertain to audit periods prior to a change in ownership and are conducted pursuant to Sections 140.30 and 140.590. Liability of current owners or operators for amounts identified during such audits shall be as follows:
  - A) For past audits (audits completed before changes in ownership), liability shall be the amount established by final administrative decision.
  - B) For pending audits (audits initiated, but not completed prior to the change in ownership), liability shall be limited to the lesser of the amounts established by final administrative decision or two months of service revenue. Two months of service revenue is defined as the most recent two months of Medicaid patient days multiplied by the total Medicaid rate in effect on the date the new owner or operator is enrolled in the Program as a provider by the Department. The Medicaid rate in effect on the date of enrollment shall be used even if that rate is subsequently changed.
  - C) For future audits (audits initiated after the change in ownership but pertaining to an audit period prior to a change in ownership), liability shall be limited as described in subsection ~~(1k)~~(4)(B) of this Section.

m) A provider that is eligible to participate in the 340B federal Drug Pricing Program under section 340B of the federal Public Health Service Act (47 USC 201 et seq.), shall enroll in that program. No entity participating in the federal Drug Pricing Program under section 340B of the federal Public Health Services Act may exclude Medicaid from their participation in that program. A provider enrolled in

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the 340B federal Drug Pricing Program must charge the Department no more than its actual acquisition cost for the drug product, plus the Department established dispensing fee. This requirement is effective October 1, 2012 for 340B providers who own and/or operate a pharmacy that bills the Department for drugs; July 1, 2013 for providers who are eligible to participate in the 340B program as Hemophilia Treatment Centers (HTCs) and for 340B providers for drugs billed to the Department by a contract pharmacy; and January 1, 2013 for all other 340B-eligible providers who bill the Department for drugs.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.13 Definitions**

"Abuse". For purposes of this Part and 89 Ill. Adm. Code 104, "abuse" means provider practices that are inconsistent with sound fiscal, business or medical practices and that result in an unnecessary cost to the Medical Assistance Program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medical Assistance Program. Abuse does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible vendor liability.

"Alternate Payee". For purposes of this Part, "Alternate Payee" shall mean an entity that is registered as an alternate payee in the Medical Assistance Program. An individual practitioner may designate payments due the practitioner be made to an alternate payee.

"Code". For purposes of this Part, "Code" means the Public Aid Code [305 ILCS 5].

"Credible Allegation". For purposes of this Part, "credible allegation" includes an allegation from any source, including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through provider audits, civil actions filed under the False Claims Act [740 ILCS 175], and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability.

"Credible Evidence". For purposes of this Part, "credible evidence" shall mean evidence that reasonable people would agree as being trustworthy and reliable.

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"Department Policy". For purposes of this Part, "Department policy" shall mean the written requirements of the Department set forth in the Medical Assistance Program Handbooks, and the Department's written manuals, bulletins and releases. It shall also include any additional policy statements transmitted in writing to a vendor.

"Entity". For purposes of this Part, "entity" means any person, firm, corporation, partnership, association, agency, institution, or other legal organization.

"Fraud". For purposes of this Part and 89 Ill. Adm. Code 104, "fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

"Harm". For purposes of this Part and 89 Ill. Adm. Code 104, "harm" means physical, mental or monetary damage to recipients or to the Medical Assistance Program.

"Investor". For purposes of this Part, "investor" shall mean any entity that owns (directly or indirectly) five percent or more of the shares of stock or other evidences of ownership of a vendor, or holds (directly or indirectly) five percent or more of the debt of a vendor, or owns and holds (directly or indirectly) three percent or more of the combined debt and equity of a vendor.

"Management Responsibility". For purposes of this Part, a person with management responsibility includes a person vested with discretion or judgment who either alone or in conjunction with others, conducts, administers or oversees either the general concerns of the vendor or a portion of the vendor's concerns. A person with management responsibility shall specifically include the pharmacist in a pharmacy, the medical director of a laboratory, the administrator of a hospital or nursing home, the dispatcher in a transportation vendor, dispatchers and all individuals in charge of day to day operations of a non-emergency transportation vendor, the person or persons responsible for preparation and submittal of billings for services to the Department, and the manager of a group practice, clinic or shared health facility.

"Non-Emergency Transportation Vendor". For purposes of this Part, non-emergency transportation vendor shall mean any transportation provider identified

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in Section 140.490(a) other than those identified in Section 140.490(a)(1) and (a)(6).

"Technical or Other Advisor". For purposes of this Part, "technical or other advisor" shall mean any entity that provides any form of advice to a vendor regarding the vendor's business or participation in the Medical Assistance Program in return for compensation, directly or indirectly, in any form.

"Vendor". For purposes of this Part, "vendor" or "provider" shall mean a person, firm, corporation, association, agency, institution, or other legal entity that provides goods or services to a recipient or recipients, and is enrolled to participate in the Medical Assistance Program pursuant to 89 Ill. Adm. Code 140.11 and 140.12.

"Waste". For purposes of this Part and 89 Ill. Adm. Code 104, "waste" means the unintentional misuse of medical assistance resources, resulting in unnecessary cost to the Medical Assistance Program. Waste does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible vendor liability.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

### Section 140.14 Denial of Application to Participate in the Medical Assistance Program

- a) The Department may deny an application to participate in the Medical Assistance Program if the vendor has engaged in activities which constitute grounds for termination, ~~or~~ suspension or exclusion under Section 140.16. If the activities were engaged in prior to December 1, 1977, they may be used as the basis for denial of an application only if the vendor had actual or constructive knowledge of the requirements which applied to his conduct or activities.
- b) Denial of Application
  - 1) ~~The~~In addition to the above basis, the Department may deny an application submitted by a vendor ~~that has been previously terminated, barred or denied participation~~ if:
    - A) ~~the~~such vendor cannot reasonably be expected to meet the written requirements of the Department including those set forth in the

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Medical Assistance Program Handbooks and the Department's manuals, bulletins and releases; or

~~B)2)~~ the Department determines, after reviewing the activities ~~that~~~~which~~ served as the basis for the earlier termination or barring, that the application should not be approved. Factors to be considered by the Department in making this determination shall include:

~~i)A)~~ length of time the vendor has not participated in the Medical Assistance Program;

~~ii)B)~~ magnitude and severity of the activities ~~that~~~~which~~ led to the binding administrative decision which served as the basis for the vendor's termination, barring or denied participation;

~~iii)C)~~ mitigating circumstances presented by the vendor;

~~iv)D)~~ whether the deficiencies ~~that~~~~which~~ served as the basis for the vendor to be terminated, barred or denied participation are corrected;

~~v)E)~~ whether the vendor demonstrates a fitness to participate in the Medical Assistance Program; and

~~vi)F)~~ the extent to which any legally enforceable debts owed to the Department by the applicant or an entity in which the applicant or his ~~or her~~ nominee held a substantial ownership interest have been paid.

~~23)~~ These factors must be established by submission of documentary evidence in support of the application.

- c) The Department may deny an application of a previously terminated or barred applicant if the applicant, without special permission from the Department, has already become a vendor, an entity with management responsibility for a vendor, an incorporator, officer or member of the board of directors of a vendor, an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship

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vendor, a partner in a partnership vendor, a technical or other advisor to a vendor, or an investor in a vendor.

- d) Effective July 1, 2012, the ~~The~~ Department shall deny an application to participate in the Medical Assistance Program of any person, firm, corporation, association, agency, institution or other legal entity; ~~if the vendor does not have a necessary license, certificate or authorization.~~
- 1) immediately, if the vendor is not properly licensed, certified or authorized;
  - 2) within 30 days after the date when the vendor's professional license, certification or other authorization has been refused renewal, restricted or revoked, suspended or otherwise terminated; or
  - 3) if the vendor has been convicted of a violation of the Public Aid Code, as provided in Article VIIIA of the Code.
- e) Effective July 1, 2012, the Department may deny the eligibility of any person, firm, corporation, association, agency, institution or other legal entity to participate as a vendor if, after reasonable notice and opportunity for a hearing, the Department finds:
- 1) The applicant or any person with management responsibility for the applicant; an officer or member of the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; an owner of a sole proprietorship applicant; a partner in a partnership applicant; or a technical or other advisor to an applicant has a debt owed to the Department, and no payment arrangements acceptable to the Department have been made by the applicant.
  - 2) The applicant or any person with management responsibility for the applicant; an officer or member of the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; an owner of a sole proprietorship applicant; a partner in a partnership vendor applicant; or a technical or other advisor to an applicant, during a period of time when the conduct of that vendor resulted in a debt owed to the Department and no payment arrangements acceptable to the Department

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have been made by that vendor, was:

- A) a person with management responsibility;
  - B) an officer or member of the board of directors of an applicant;
  - C) an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor;
  - D) an owner of a sole proprietorship;
  - E) a partner in a partnership vendor; or
  - F) a technical or other advisor to a vendor.
- 3) There is a credible allegation, as defined in Section 140.13, of the use, transfer or lease of assets of any kind to an applicant from a current or prior vendor who has a debt owed to the Department, no payment arrangements acceptable to the Department have been made by that vendor or the vendor's alternate payee, and the applicant knows or should have known of the debt.
- 4) There is a credible allegation of a transfer of management responsibilities, or direct or indirect ownership, to an applicant from a current or prior vendor who has debt owed to the Department, and no payment arrangements acceptable to the Department have been made by the vendor or the vendor's alternate payee, and the applicant knows or should have known of the debt.
- 5) There is a credible allegation of the use, transfer or lease of assets of any kind to an applicant who is a spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, relative by marriage, nephew, cousin or other relative of a current or prior vendor who has a debt owed to the Department and no payment arrangements acceptable to the Department have been made.
- 6) There is a credible allegation that the applicant's previous affiliations with a provider of medical services that has an uncollected debt, a provider that has been or is subject to a payment suspension under a federal health care

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program, or a provider that has been previously excluded from participation in the Medical Assistance Program, poses a risk of fraud, waste or abuse to the Department.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.15 Suspension and Denial of Payment, Recovery of Money and Penalties**

- a) Effective July 1, 2012, the~~The~~ Department may suspend or deny payment, in whole or in part, to a vendor or the vendor's alternate payee if the payment would be improper or erroneous or would otherwise result in overpayment. The Department may recover money improperly or erroneously paid, or overpayments (see subsection (b) of this Section for exception to recovery of money), made to a vendor or vendor's alternate payee, either by setoff (deducting from Department obligations to the vendor or the designated alternate payee), deductions from future billings or by requiring direct repayment. Payments may be suspended, denied or recovered from a vendor or alternate payee:
- 1) for services rendered in violation of the Department's provider notices, statutes, rules and regulations;
  - 2) for services rendered in violation of the terms and conditions prescribed by the Department in its vendor agreement;
  - 3) for any vendor who fails to grant the Office of Inspector General of the Department timely access to full and complete records, including, but not limited to, records relating to recipients under the Medical Assistance Program for the most recent six years, in accordance with Section 140.28, and other information for the purpose of audits, investigations or other program integrity functions, after reasonable written request by the Inspector General; provided, however, that this subsection (a)(3) does not require vendors to make available the medical records of patients for whom services are not reimbursed under this Part or to provide access to medical records more than six years old;
  - 4) when the vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Medical Assistance Program;

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- 5) when the vendor previously rendered services while terminated, suspended or excluded from participation in the Medical Assistance Program or while terminated or excluded from participation in another state or federal medical assistance or health care program; or
- 6) for ground ambulance services rendered as the result of improper or false certification. Overpayments can be recovered from a vendor, including, but not limited to, from the discharging physician, the discharging facility, and the ground ambulance service provider.
- b) If a practitioner designates an alternate payee, the practitioner and the alternate payee shall be jointly and severally liable to the Department for payments made to the alternate payee. Recoveries by the Department may be made against either party or both, at the Department's option.
- c) The Department shall not recoup from any long term care provider any amounts subsequently determined to be owed by a client due to an error in the initial determination of medical eligibility.
- d) Effective July 1, 2012, if ~~The Department shall recover interest on the amount of the overpayment at the rate of five percent per annum if~~ it is established through an administrative hearing that ~~an~~the overpayment resulted from ~~at~~the vendor or the designated alternate payee ~~knowingly willfully~~ making, using, or causing to be made or used, a false record or statement to obtain payment or other benefit from or misrepresentation of a material fact in connection with billings and payments under the medical assistance program, in addition to any other penalties that may be prescribed by law:-
- 1) the Department may recover interest (based on criteria in 89 Ill. Adm. Code 104.206(d)(2)) on the amount of the overpayment or other benefit from the vendor or alternate payee at the rate of 5% per annum;
- 2) the vendor or alternate payee shall be subject to civil penalties consisting of an amount not to exceed three times the amount of payment or other benefit resulting from each false record or statement; and
- 3) the vendor or alternate payee shall be subject to payment of a penalty of \$2,000 for each false record or statement for payment or other benefit.

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- e) Effective July 1, 2012, for~~For~~ purposes of this Section, "knowingly"~~"willfully"~~ means that a vendor or alternate payee, with respect to information:
- i) has actual knowledge of the information;
  - ii) acts in deliberate ignorance of the truth or falsity of the information; or
  - iii) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.~~making a statement or representation with actual knowledge that it was false, or making a statement or representation with knowledge of facts or information that would cause a reasonable person to be aware that the statement or representation was false when made.~~
- f) If a vendor has the same taxpayer identification number (assigned under section 6109 of the Internal Revenue Code of 1986) as is assigned to a vendor with past-due financial obligations to the Department, the Department may make any necessary adjustments to payments to that vendor in order to satisfy any past-due obligations, regardless of whether the vendor is assigned a different billing number under the Medical Assistance Program.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.16 Termination, ~~or~~ Suspension or Exclusion of a Vendor's Eligibility to Participate in the Medical Assistance Program**

- a) Effective July 1, 2012, the~~The~~ Department may terminate or suspend a vendor's eligibility to participate in the Medical Assistance Program, ~~or~~ terminate or not renew a vendor's provider agreement, or exclude a person or entity from participation in the Medical Assistance Program, when it determines that, at any time:
- 1) The vendor is not complying with the Department's policy or rules, or with the terms and conditions prescribed by the Department in any vendor agreement developed as a result of negotiations with the vendor category, or with the covenants contained in certifications bearing the vendor's signature on claims submitted to the Department by the vendor, or with restrictions on participation imposed pursuant to Section 140.32(f);

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- 2) The vendor, person or entity is not properly licensed, certified, authorized or otherwise qualified, or the vendor person's or entity's ~~vendor's~~ professional license, certificate or other authorization has not been renewed or has been restricted, revoked, suspended or otherwise terminated as determined by the appropriate licensing, certifying or authorizing agency. The termination, suspension or exclusion shall be immediately effective;
- 3) The vendor violates records requirements as set forth in statute or Department rules, provider handbooks or policies.
  - A) The vendor has failed to keep or timely make available for inspection, audit or copying (including photocopying), after receiving a written request from the Department:
    - i) records required to be maintained by the Department or necessary to fully and completely disclose the extent of the services or supplies provided; or
    - ii) full and complete records required to be maintained by the Department regarding payments claimed for providing services.
  - B) This subsection (a)(3) does not require vendors to make available medical records of patients for whom services are not reimbursed under the Illinois Public Aid Code;
- 4) The vendor has failed to furnish any information requested by the Department regarding payments for providing goods or services, or has failed to furnish all information required by the Department in connection with the rendering of services or supplies to recipients of public assistance by the vendor or his or her agent, employer or employee;
- 5) The vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Medical Assistance Program. For purposes of this subsection (a)(5), statements or representations made "knowingly" shall include statements or representations made with actual knowledge that they were false as well as those statements made when the individual

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making the statement had knowledge of such facts or information as would cause one to be aware that the statements or representations were false when made;

- 6) The vendor has submitted claims for services or supplies that were not rendered or delivered by that vendor;
- 7) The vendor has furnished goods or services to a recipient that, when based upon competent medical judgment and evaluation, are determined to be:
  - A) in excess of ~~the recipient's~~ needs;
  - B) harmful ~~to the recipient~~ (for the purpose of this subsection (a)(7)(B), "harmful" goods or services ~~cause~~ caused actual harm as defined in Section 140.13 to a recipient or placed an individual a recipient at risk of harm, or of adverse side effects, that ~~outweigh~~ outweighed the medical benefits sought ~~to be provided~~);  
or
  - C) of grossly inferior quality;
- 8) The vendor knew or should have known that a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an investor in the vendor, a technical or other advisor of the vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor was previously terminated, suspended, excluded or barred from participation in the Medical Assistance Program, or in another state or federal medical assistance or health care program;
- 9) The vendor has a delinquent debt owed to the Department;
- 10)9) The vendor engaged in practices prohibited by federal ~~Federal~~ or State law or regulation.
  - A) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate

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or limited liability company vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor, either:

- i) has engaged in practices prohibited by applicable ~~federal~~Federal or State law or regulation; or
  - ii) was a person with management responsibility for a vendor at the time that the vendor engaged in practices prohibited by applicable ~~federal~~Federal or State law or regulation; or
  - iii) was an officer, or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a vendor at the time the vendor engaged in practices prohibited by applicable ~~federal~~Federal or State law or regulation; or
  - iv) was an owner of a sole proprietorship or partner of a partnership that was a vendor at the time the vendor engaged in practices prohibited by applicable ~~federal~~Federal or State law or regulation;
- B) For purposes of this subsection (a)(~~109~~), "applicable ~~federal~~Federal or State law or regulation" includes, but is not limited to, shall include licensing or certification standards contained in State or ~~federal~~Federal law or regulations related to the Medical Assistance Program, any other licensing standards as they relate to the vendor's practice or business or any ~~federal~~Federal or State laws or regulations related to the Medical Assistance Program;
- C) For purposes of this subsection (a)(~~109~~), conviction or a plea of guilty to activities violative of applicable ~~federal~~Federal or State law or regulation shall be conclusive proof that those activities were engaged in;
- ~~11)10)~~ The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner

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of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor has been convicted in this or any other State, or in any Federal Court, of any ~~offense~~felony not related to the Medical Assistance Program, if the ~~offense~~felony constitutes grounds for disciplinary action under the licensing Act applicable to that individual or vendor;

~~12)11)~~ The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or partner in a partnership that is a vendor has been convicted in this or any other state, or in any Federal ~~Courteourt~~, of:

A) ~~of~~ murder; ~~or~~

B) a Class X felony under the Illinois Criminal Code of 1961;

C) ~~sexual misconduct that may subject recipients to an undue risk of harm;~~

D) ~~a criminal offense that may subject recipients to an undue risk of harm;~~

E) ~~a crime of fraud or dishonesty;~~

F) ~~a crime involving a controlled substance;~~

G) ~~a misdemeanor relating to fraud, theft, embezzlement or breach of fiduciary responsibility; or~~

H) ~~other financial misconduct related to a health care program.~~

~~13)12)~~ The direct or indirect ownership of the terminated, suspended or excluded vendor (including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a partnership, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor) has been transferred by an individual ~~who is terminated or barred from participating as a vendor~~ to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin

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or relative by marriage.

- b) The Department may suspend a vendor's eligibility to participate in the Medical Assistance Program if the vendor is not in compliance with State income tax requirements, child support payments in accordance with Article X of the Public Aid Code, or educational loans guaranteed by the Illinois Student Assistance Commission. The vendor may prevent suspension of eligibility by payment of past-due amounts in full or by entering into payment arrangements acceptable to the appropriate State agency.
- c) Effective July 1, 2012, the Department may terminate, suspend or exclude vendors who pose a risk of fraud, waste, abuse or harm, as defined in Section 140.13, from participation in the Medical Assistance Program.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.18 Effect of Termination, Suspension, Exclusion or Revocation on Persons Associated with Vendor**

- a) Upon termination, suspension or exclusion of a vendor of goods or services from participation in the Medical Assistance Program, a person with management responsibility for such vendor during the time of any conduct that served as the basis for that vendor's termination, suspension or exclusion is barred from participation in the Medical Assistance Program.
- b) Upon termination, suspension or exclusion of a corporate vendor, the officers and persons owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in the vendor during the time of any conduct that served as the basis for that vendor's termination, suspension or exclusion are barred from participation in the Medical Assistance Program.
- c) Upon termination, suspension or exclusion of a sole proprietorship or partnership, the owner or partners during the time of any conduct that served as the basis for that vendor's termination, suspension or exclusion are barred from participation in the Medical Assistance Program.
- d) Upon revocation of an alternate payee pursuant to Section 140.1005, the owners, officers, and individuals with management responsibility for the alternate payee during the time of any conduct that served as the basis for that alternate payee's

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revocation may be prohibited from participation as an owner, an officer, or an individual with management responsibility for an alternate payee in the Illinois Medical Assistance Program.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension, Exclusion or Barring**

- a) A vendor that has been terminated, suspended or excluded from the Medical Assistance Program may not apply to participate for at least one year after the date of the final administrative decision terminating, suspending or excluding eligibility, except that, if a vendor has been terminated, suspended or excluded based on a conviction of a violation of Article VIIIA of the Public Aid Code [~~305 ILCS 5/Art. VIIIA~~] or a conviction of a felony based on fraud or a willful misrepresentation related to subsection (a)(1), (2); or (3) or (4) of this Section, the vendor shall be barred from participation for five years or for the length of the vendor's sentence for that conviction, whichever is longer.
- 1) The Medical Assistance Program under Article V of the Public Aid Code [~~305 ILCS 5/Art. V~~];
  - 2) A federal or another state's medical assistance or health care program ~~in another state that is the kind provided under Article V of the Public Aid Code; or~~
  - 3) ~~The Medicare program under Title XVIII of the Social Security Act; or~~
  - 3)4) The provision of health care services.
- b) After one year, a vendor who has been terminated, suspended or excluded for any reason, other than for the reasons in subsections (a)(1) through (3)(4) of this Section, may apply for reinstatement to the Medical Assistance Program. If a vendor's application for reinstatement is denied by the Department, he or she shall be barred from again applying for reinstatement for one year after the date of the final administrative decision denying his or her application for reinstatement.
- c) A vendor whose termination, suspension or exclusion from participation in the Illinois Medical Assistance Program under Article V was based solely on an

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action by a governmental entity other than the Department may, upon reinstatement by that governmental entity or upon reversal of the termination, suspension or exclusion from participation in the Medical Assistance Program. Upon proper application for rescission, the vendor may be deemed eligible by the Director if the vendor meets the requirements for eligibility under the Public Aid Code.

- d)e) At the end of a period of suspension, a vendor that has been suspended from the Medical Assistance Program shall be reinstated upon completion of the necessary enrollment forms and execution of a new vendor agreement unless it is determined that such vendor has not corrected the deficiencies upon which the suspension was based. If the deficiencies have not been corrected, the vendor shall, after notice and hearing, be terminated. The notice in any termination action based on this Section shall notify the vendor of the deficiencies not corrected.
- e)d) An individual barred pursuant to Section 140.18 can apply to participate in the Medical Assistance Program. If an individual's application is denied by the Department or if he or she is denied special permission under Section 140.32, he or she shall be barred from again applying for one year after the date of the final administrative decision denying his or her application or special permission.
- f)e) If a vendor has been terminated, suspended or excluded and reinstated to the Medical Assistance Program and the vendor is terminated, suspended or excluded a second or subsequent time from the Medical Assistance Program, the vendor shall be barred from participation for at least two years, except that, if a vendor has been terminated, suspended or excluded a second time based on a conviction of a violation of Article VIII A of the Public Aid Code ~~[305 ILCS 5/Art. VIII A]~~ or a conviction of a felony based on fraud or a willful misrepresentation related to subsection (a)(1), (2), or (3) or (4) of this Section, the vendor shall be barred from participation for life.
- g)f) At the end of two years, a vendor who has been terminated, suspended or excluded for any reason, other than for the reasons in subsections (a)(1) through ~~(34) of this Section~~, may apply for reinstatement to the Medical Assistance Program. If a vendor's application for reinstatement is denied by the Department, he or she shall be barred from again applying for reinstatement for two years after the date of the final administrative decision denying his or her application for reinstatement.

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(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.20 Submittal of Claims**

- a) When claims for payment are submitted to the Department, providers shall:
- 1) Use Department designated billing forms or electronic format for submittal of charges~~;~~ and
  - 2) Certify that:
    - A) They have personally rendered the services and provided the items for which charges are being made~~;~~
    - B) Payment has not been received, or that only partial payment has been received~~;~~
    - C) The charge made for each item constitutes the complete charge~~;~~
    - D) They have not, and will not, accept additional payment for any item from any person or persons~~;~~ and
    - E) They will not make additional charges to, nor accept additional payment from, any persons if the charges they present are reduced by the Department to conform to Department standards.
- b) Statement of Certification
- 1) All billing statements shall contain a certification statement that must remain unaltered, and must be legibly signed and dated in ink by the provider, his or her designated alternate payee, or his or her authorized representative. A rubber stamp or facsimile signature is not acceptable.
  - 2) An "authorized representative" may only be a trusted employee over whom the provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the provider. ~~The~~~~Such~~ representative must be specifically designated and must sign the provider's name and his or her own initials on each certification statement.

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- 3) An alternate payee must be specifically designated by the provider and must sign the provider's name and alternate payee's authorized representative's initials on each certification statement.
- c) Effective July 1, 2012, to~~Fe~~ be eligible for payment consideration, a provider's vendor-payment claim or bill, either as an initial or resubmitted claim following prior rejection, that can be processed without obtaining additional information from the provider of the service or from a third party, must be received by the Department, or its fiscal intermediary, no later than 180 days~~12 months~~ after the date on which medical goods or services were provided, with the following ~~exceptions:~~ exception. The Department must receive a claim after disposition by Medicare or its fiscal intermediary no later than 24 months after the date on which medical goods or services were provided.
- 1) The Department must receive a claim after disposition by Medicare or its fiscal intermediary no later than 24 months after the date on which medical goods or services were provided.
  - 2) In the case of a provider whose enrollment is in process by the Department, the 180-day period shall not begin until the date on the written notice from the Department that the provider enrollment is complete.
  - 3) In the case of errors attributable to the Department or any of its claims processing intermediaries that result in an inability to receive, process or adjudicate a claim, the 180-day period shall not begin until the provider has been notified of the error.
  - 4) In the case of a provider for whom the Department initiates the monthly billing process.
  - 5) For claims for rendered during a period for which a recipient received retroactive eligibility, claims must be filed within 180 days after the Department determines the applicant is eligible.
  - 6) For claims for which the Department is not the primary payer, claims must be submitted to the Department within 180 days after the final adjudication by the primary payer.

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- 7) In the case of long term care facilities, admission documents shall be submitted within 30 days after an admission to the facility through the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System, or shall be submitted directly to the Department of Human Services using required admission forms. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.
- 8) For hospital inpatient claims, the 180 days is measured from the date of discharge.

- d) Claims that are not submitted and received in compliance with the foregoing requirements will not be eligible for payment under the Department's Medical Assistance Program, and the State shall have no liability for payment of the claim.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.30 Audits**

- a) Effective July 1, 2012, whether pre-payment or post-payment, all AH services for which charges are made to the Department are subject to audit. During a review audit, the provider shall furnish to the Department or to its authorized representative, pertinent information regarding claims for payment. If records are maintained by a designated alternate payee, it is the provider's responsibility to obtain the records and furnish them to the Department. Should an audit reveal that incorrect payments were made, or that the provider's records do not support the payments that were made, or should the provider or designated alternate payee fail to furnish records to support payments that were made, the provider or designated alternate payee shall make restitution.
- b) The Department's procedure for auditing providers may involve the use of sampling and extrapolation. Under such a procedure, the Department selects a statistically valid sample of the cases for which the provider or designated alternate payee received payment for the audit period in question and audits the provider's records for those cases. All incorrect payments determined by an audit of the cases in the sample are then totaled and extrapolated to the entire universe

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of cases for which the provider or designated alternate payee has been paid during the audit period. The provider or designated alternate payee shall be required to pay the Department the entire extrapolated amount of incorrect payments calculated under this procedure after notice and opportunity for hearing pursuant to 89 Ill. Adm. Code 104.210.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.32 Prohibition on Participation, and Special Permission for Participation**

- a) Prohibition on Participation by Terminated, Suspended, Excluded or Barred Entities
  - 1) Upon being terminated, suspended, excluded or barred, and while thesueh disability from Medical Assistance Program participation remains in effect, an entity:
    - A) Cannot be a vendor, assume management responsibility for a vendor, own (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership of a corporate vendor, become an owner of a sole proprietorship that is a vendor, become a partner of a vendor or become an officer of a corporate vendor;
    - B) Cannot be an employer of a vendor; a person with management responsibility for an employer of a vendor; an officer of an employer of a vendor; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in an employer of a vendor; an owner of a sole proprietorship that employs a vendor; or a partner of a partnership that employs a vendor;
    - C) Cannot order goods or services from a vendor when payment for such goods or services will be made in whole or in part by the Department;
    - D) Cannot render goods or services as an employee of a vendor or as an independent contractor with a vendor for which payment will be made in whole or in part by the Department;

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- E) Cannot, directly or indirectly, serve as a technical or other advisor to a vendor;
  - F) Cannot, directly or indirectly, be an incorporator or member of the board of directors of a vendor;
  - G) Cannot, directly or indirectly, be an investor in a vendor; and
  - H) Cannot own (directly or indirectly) a 5% or greater interest in any premises or equipment leased by a vendor.
- 2) An individual who is terminated or barred from participation in the Medical Assistance Program cannot transfer the direct or indirect ownership of a vendor (including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a partnership, or ownership of 5% or more of the shares of stock or other evidences of ownership in a ~~corporate~~-vendor) to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.
- 3) Effective July 1, 2012, a person who owns, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor who owes a debt to the Department, if that vendor has not made payment arrangements acceptable to the Department, shall not transfer his or her ownership interest in that vendor, or vendor assets of any kind, to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin or relative by marriage.
- 4)3) After the provision of written notice to the affected parties, the Department may deny payment for goods or services rendered or ordered by an entity that violates the provisions of subsectionsubsections (a)(1)(A), (B), (C) or (D) ~~of this Section~~. The Department may also pursue the imposition of all criminal and civil penalties as may be available and necessary.
- 5)4) Whenever an entity violates the provisions of subsectionsubsections (a)(1)(E), (F), (G) or (H) ~~of this Section~~ the Department may refer the matter for filing of an appropriate civil suit by the Attorney General or the

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State's Attorney to recover all benefits obtained improperly as well as treble damages or \$10,000.00 for each such violation whichever amount is greater, in accordance with Section 11-27 of the Public Aid Code ~~[305 ILCS 5/11-27]~~.

- b) Special Permission for Continuation or Reinstatement of Medical Assistance Program Participation for Barred Entities
- 1) Any entity barred pursuant to Section 140.18 may seek special permission to continue participation in the Medical Assistance Program or for reinstatement in the Program.
  - 2) Special permission shall be granted only if the entity seeking such action demonstrates to the Department that it had no part in, and no knowledge of, the conduct which led to the decision to terminate upon which the barring was based or that it had no part in, and notified the Department as soon as it gained knowledge of, the conduct.
  - 3) In deciding whether to authorize the continued participation by, or reinstatement of, an entity that meets the conditions of this subsection (b) the Director shall consider the following factors:
    - A) Whether the entity requesting special permission demonstrates a fitness to participate in the Medical Assistance Program;
    - B) The extent to which any legally enforceable debts owed to the Department by the applicant or an entity in which the applicant or his nominee held a substantial ownership interest have been paid;
    - C) Any other circumstances reasonably related to the issue of whether the special permission should be granted.
  - 4) Any entity that seeks special permission to continue or reinstate benefits shall submit a written request to the Director. Upon receipt of such a request, the Director or his designee shall review the request and any supporting documentation which accompanies it, and shall notify the entity of the decision within 60 days ~~after~~ receipt of the request, where practicable. In reviewing the request, the Director may require the entity to appear before and cooperate with a peer review committee of the

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Department.

- 5) An entity may request special permission only once. An entity that has been denied special permission may not apply for readmission under Section 140.14 for one year after the final decision to deny special permission. An entity that has been denied readmission under Section 140.14 or has an application under Section 140.14 pending with the Department may not apply for special permission.
- 6) Whenever a barred entity is readmitted to the Medical Assistance Program pursuant to this Section, the Director may make the vendor's continued participation contingent upon compliance with specified restrictions, including, but not limited to:
  - A) Limiting the participation by the entity as to the location, type, volume or category of goods or services to be provided;
  - B) Requiring that the entity obtain continuing education, or additional licenses or authorizations; and
  - C) Any other terms or conditions which may be appropriate or required under the circumstances.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.44 Withholding of Payments Due to Fraud or Misrepresentation**

- a) ~~Effective July 1, 2012, payments~~ **Payments** on pending and subsequently submitted bills may be withheld, in whole or in part, to a provider or alternate payee, ~~when there is credible~~ **upon receipt by the Department of** evidence from State or ~~federal~~ **Federal** law enforcement or ~~federal~~ **Federal** oversight agencies or from the results of a preliminary Department audit ~~and determined by the Department to be credible~~, that the circumstances giving rise to the need for a withholding of payments may involve fraud or willful misrepresentation under the Illinois Medical Assistance Program. ~~For purposes of this Section, "credible evidence" is defined as evidence that reasonable people would agree as being trustworthy and reliable.~~ Payments may be withheld without first notifying the provider or alternate payee of its intention to withhold the payments.

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- b) The Department must send notice of its withholding within 5 days after taking that action. The notice must set forth the general allegations as to the nature of the withholding, but need not disclose any specific information concerning the ongoing investigation. The notice must also state the following:
- 1) The payments are being withheld in accordance with Section 12-4.25(K) of the Public Aid Code~~305 ILCS 5/12-4.25 (K)~~.
  - 2) The withholding is for a temporary period; the notice shall cite the circumstances under which withholding will be terminated.
  - 3) When appropriate, the type of claim for which withholding is effective.
  - 4) The provider or alternate payee has the right to submit written evidence for reconsideration of the withholding of payments by the Department.
  - 5) A written request may be made to the Department for full or partial release of withheld payments and the request may be made at any time after the Department first withholds the payments.
- c) All withholding of payment actions under this Section shall be temporary and shall not continue after any of the following:
- 1) The Department or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the provider or alternate payee.
  - 2) Legal proceedings related to the provider's or alternate payee's alleged fraud, willful misrepresentation, or violations of Article V of the Illinois Public Aid Code ~~[305 ILCS 5/Art. V]~~ or violations of 89 Ill. Adm. Code: Chapter I are completed. If the Department commences an administrative proceeding that seeks the termination of the provider or revocation of the alternate payee, withholding will continue in conformance with 89 Ill. Adm. Code 104.272.
  - 3) The withholding of payments for a period of 3 years.
- d) The provider or alternate payee request for reconsideration of payment withholding, or request for full or partial release of payments withheld, must be in

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writing, set out the reasons for the request, and be sent to the Department's Office of Inspector General at 404 North Fifth Street, Springfield, Illinois 62706, or by e-mail to HFS.OIGWebmaster@illinois.gov or oigwebmaster@illinois.gov. The request may include documentation that the allegations of fraud or willful misrepresentation involving the Medical Assistance Program did not take place.

- e) Partial or full release of payments on pending and subsequently submitted bills may be granted, at the discretion of the Inspector General of the Department, when it is in the best interest of the recipients of medical assistance. This may include, but not be limited to, access to medical services for recipients or the potential movement of patients from long term care settings.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.45 Withholding of Payments Upon Provider Audit, Quality of Care Review, Credible Allegation of Fraud or Failure to Cooperate**

- a) Effective July 1, 2012, the Department may withhold payments, in whole or in part, to a provider or alternate payee upon:
- 1) initiation of an audit;
  - 2) quality of care review;
  - 3) investigation in which there is a credible allegation of fraud; or
  - 4) the provider or alternate payee is demonstrating a clear failure to cooperate with the Department, giving rise to the need for a withholding of payments.
- b) The Department may withhold payments without first notifying the provider or alternate payee of its intention to withhold payments.
- c) A provider or alternate payee may request a hearing or a reconsideration of payment withholding, and the Department must grant the request.
- d) The Department must send notice of its withholding of payments within five days after taking the action. The notice shall:

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- 1) Set forth the general allegation as to the nature of the withholding action; however, the notice need not disclose any specific information concerning an ongoing investigation.
  - 2) State that payments are being withheld in accordance with Section 12-4.25(K-5) of the Code.
  - 3) State that the withholding is for a temporary period, as specified in subsection (g), and cite the circumstances under which withholding will be terminated.
  - 4) Specify, when appropriate, which type or types of claims are withheld.
  - 5) Inform the provider or alternate payee of the right to request a hearing or a reconsideration of the withholding by the Department, including the ability to submit written evidence.
  - 6) Inform the provider or alternate payee that a written request may be made to the Department for a hearing or reconsideration for the full or partial release of withheld payments and that such requests may be made at any time after the Department first withholds payments.
- e) A provider or alternate payee may request reconsideration of payment withholding for the purpose of a full or partial release of payments withheld pursuant to Section 12-4.25(K-5) of the Code. The provider or alternate payee shall submit a written request for reconsideration and the reasons for the reconsideration to the Department's Inspector General at:

Office of Inspector General  
404 North Fifth Street  
Springfield, Illinois 62706

Or by e-mail to: [HFS.OIGWebmaster@illinois.gov](mailto:HFS.OIGWebmaster@illinois.gov).

- 1) The request may include documentation to contest a credible allegation of fraud or failure to cooperate with the Department.
- 2) Partial or full release of payments on pending and subsequently submitted bills may be granted, at the discretion of the Inspector General, when it is

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in the best interest of Medical Assistance Program recipients. Factors in this decision may include, but are not limited to, recipients' access to medical services or the potential transport of patients from long term care settings.

- f) A provider or alternate payee may request a hearing on the issue of a withholding of payments pursuant to Section 12-4.25(K-5) of the Code. The only issue at hearing will be whether a partial or full release of funds is properly based on the following factors:
- 1) Whether there is a credible allegation of fraud;
  - 2) Whether the provider or alternate payee demonstrated a clear failure to cooperate with the Department, giving rise to the need for a withholding of payments;
  - 3) Whether a release is in the best interest of the recipients of medical assistance based on access to medical services for recipients; and
  - 4) The potential movement of patients from long term care settings.
- g) All withholding of payment actions under this Section shall be temporary and shall not continue after either of the following:
- 1) The Department determines that there is insufficient evidence of fraud, or the provider or alternate payee demonstrates clear cooperation with the Department, as determined by the Department, so that the circumstances do not give rise to the need for withholding of payments; or
  - 2) the withholding of payments has lasted for a period in excess of three years.

(Source: Added at 37 Ill. Reg. 10282, effective June 27, 2013)

## SUBPART C: PROVIDER ASSESSMENTS

**Section 140.80 Hospital Provider Fund**

- a) Purpose and Contents

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- 1) The Hospital Provider Fund (Fund) was created in the State Treasury on February 3, 2004 (see 305 ILCS 5/5A-8). Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.
  - 2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Sections 305 ILCS 5/5A-4 and 12 of the Code.
  - 3) The Fund shall consist of:
    - A) All monies collected or received by the Department under subsection (b) ~~of this Section~~;
    - B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;
    - C) Any interest or penalty levied in conjunction with the administration of the Fund;
    - D) Monies transferred from another fund in the State treasury;
    - E) All other monies received for the Fund from any other source, including interest earned on those monies.
- b) Provider Assessments
- 1) An annual assessment on hospital inpatient services is imposed on each hospital provider in an amount equal to the hospital's occupied bed days multiplied by \$84.19 for State fiscal years 2004 and 2005, if the payment methodologies required under 305 ILCS 5/5A-12 and the waiver created under 42 CFR 433.68 are approved with an effective date prior to July 1, 2004; or the assessment will be imposed for fiscal year 2005 only, if the payment methodologies required under 305 ILCS 5/5A-12 and the waiver created under 42 CFR 433.68 are approved with an effective date on or after July 1, 2004. The Department shall use the number of occupied bed days as reported, by February 3, 2004 (the date of enactment of Public Act

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93-0659), by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health to calculate the hospital's annual assessment. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals or if there are data errors in the reported sum of a hospital's occupied bed days as determined by the Department, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

- 2) Subject to the provisions of 305 ILCS 5/5A-3 and 5A-10, for the privilege of engaging in the occupation of hospital provider, beginning August 1, 2005, an annual assessment is imposed on each hospital provider for State fiscal years 2006, 2007 and 2008, in an amount equal to 2.5835 percent of the hospital provider's adjusted gross hospital revenue for inpatient services and 2.5835 percent of the hospital provider's adjusted gross hospital revenue for outpatient services. If the hospital provider's adjusted gross hospital revenue is not available, then the Department may obtain the hospital provider's adjusted gross hospital revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.
- 3) Subject to Sections 5A-3, ~~and 5A-10~~ and 5A-15 of the Public Aid Code, for State fiscal years 2009 through 2014 and the portion of State fiscal year 2015 that ends December 31, 2014, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to \$218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days. For State fiscal years 2009 through 2014 and the portion of State fiscal year 2015 that ends December 31, 2014, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's occupied bed days and Medicare bed days from any

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source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

## c) Payment of Assessment Due

- 1) For State fiscal years through 2008, the annual assessment shall be due and payable in quarterly installments, each equaling one-fourth of the assessment for the year on the 14<sup>th</sup> business day of September, December, March and May. The assessment imposed by Section 5A-2 for State fiscal year 2009 and each subsequent State fiscal year shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the 14<sup>th</sup> State business day of each month. No installment payments of an assessment shall be due and payable, however, until after:
  - A) The Department notifies the hospital provider, in writing, that the payment methodologies to hospitals required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2, whichever is applicable for that fiscal year, have been approved by CMS and any waiver necessary under 42 CFR 433.68 has been granted by CMS; and
  - B) For State fiscal years through 2008, the hospital has received payments required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2, whichever is applicable for that fiscal year. For State fiscal year 2009 and each subsequent State fiscal year, the Comptroller has issued payments required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2, whichever is applicable for that fiscal year.
- 2) Assessment payments postmarked on the due date will be considered as paid on time. Upon notification to the Department of approval of the payment methodologies to hospitals required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2, and any waiver necessary under 42 CFR 433.68 has been granted by the CMS, all installments otherwise due prior to the date of notification shall be due and payable to the Department upon written direction from the Department and the receipt of the payments required under Section 5A-12, 5A-12.1 or 5A-12.2.

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- 3) Any assessment amount that is due and payable to the Department more frequently than once per calendar quarter shall be remitted to the Department by the hospital provider by means of electronic funds transfer. The Department may provide for remittance by other means if the amount due is less than \$10,000 or electronic funds transfer is unavailable for this purpose.
  - 4) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.
- d) Notice Requirements, Penalty, and Maintenance of Records
- 1) The Department shall send a notice of assessment to every hospital provider subject to an assessment under subsection (b) of this Section, except that no notice shall be sent until the Department receives written notice that the payment methodologies to hospitals required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2 have been approved and the waiver under 42 CFR 433.68 has been granted by CMS.
  - 2) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, a separate notice shall be sent for each hospital.
- e) Procedure for Partial Year Reporting/Operating Adjustments
- 1) Cessation of business during the fiscal year in which the assessment is being paid. If a hospital provider ceases to conduct, operate, or maintain a hospital for which the person is subject to assessment under subsection (b) ~~of this Section~~, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) ~~of this Section~~ by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate or maintain a hospital, the person shall pay the assessment for the year as adjusted (to the extent not previously paid).

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- 2) Commencing of business during the fiscal year in which the assessment is being paid. A hospital provider who commences conducting, operating, or maintaining a hospital for which the person is subject to assessment under subsection (b) ~~of this Section~~, upon notice by the Department, shall pay the assessment under subsection (d) ~~of this Section~~ as computed by the Department in installments on the due dates stated on the notices and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment notice. For State fiscal years 2006 through 2008, in determining the annual assessment amount for the provider, the Department shall develop hypothetical adjusted gross hospital revenue for the hospital's first full fiscal year, which may be based on the annualization of the provider's actual revenues for a portion of the year, or revenues of a comparable hospital for the year, including revenues realized by a prior hospital provider of the same hospital during the year. For State fiscal years 2009 through 2014 and the portion of State fiscal year 2015 that ends December 31, 2014, in the case of a hospital provider that did not conduct, operate or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Department. The assessment determination made by the Department is final.
- 3) Partial Calendar Year Operation Adjustment. For a hospital provider that did not conduct, operate, or maintain a hospital throughout the entire calendar year reporting period, the assessment for the State fiscal year shall be annualized based on the provider's actual adjusted gross hospital revenue information for the portion of the reporting period the hospital was operational (dividing adjusted gross hospital revenue by the number of days the hospital was in operation and then multiplying the amount by 365). Adjusted gross hospital revenue information reported by a prior provider from the same hospital during the calendar year shall be used in the annualization equation, if available.
- 4) Change in Ownership and/or Operators. The full quarterly installment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the hospital provider currently operating or maintaining the hospital regardless if these amounts

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were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1)-~~of this Section.~~

## f) Penalties

- 1) Any hospital that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to ~~5% five percent~~ of the amount of the installment not paid on or before the due date, plus ~~5% five percent~~ of the portion ~~thereof~~ remaining unpaid on the last day of each monthly period thereafter, not to exceed 100 percent of the installment amount not paid on or before the due date. Waiver due to reasonable cause may include but is not limited to:
  - A) provider has not been delinquent on payment of an assessment due, within the last three calendar years from the time the delinquency occurs.
  - B) provider can demonstrate to the Department's satisfaction that a payment was made prior to the due date.
  - C) provider is a new owner/operator and the late payment occurred in the quarter in which the new owner/operator assumed control of the facility.
- 2) Within 30 days after the due date, the Department may begin recovery actions against delinquent hospitals participating in the Medicaid Program. Payments may be withheld from the hospital until the entire assessment, including any interest and penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached or if a hospital fails to comply with an agreement, the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the hospital's future payments from the Department. The provider may appeal this recoupment in accordance with the

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Department's rules at 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) ~~of this Section~~ will continue to accrue during the recoupment process. Recoupment proceedings against the same hospital two times in a fiscal year may be cause for termination from the Medicaid Program. Failure by the Department to initiate recoupment activities within 30 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

- 3) If the hospital does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment – Groups of Hospitals

The Department may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

- 1) The State delays payments to hospitals due to problems related to State cash flow; or
- 2) A cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the assessment.

h) Delayed Payment – Individual Hospitals

In addition to the provisions of subsection (g) ~~of this Section~~, the Department may delay assessments for individual hospitals that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) ~~of this Section~~. The request must be received by the Department prior to the due date of the assessment.

- 1) Criteria. Delayed payment provisions may be instituted only under

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extraordinary circumstances. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

- A) The provider has experienced an emergency that necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) ~~of this Section~~ would impose severe and irreparable harm to the clients served. Circumstances that may create ~~thesesueh~~ emergencies include, but are not limited to, the following:
- i) Department system errors (either automated system or clerical) that have precluded payments, or that have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired;
  - ii) Cash flow problems encountered by a provider that are unrelated to Department technical system problems and that result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.
- B) The provider serves a significant number of clients under the medical assistance program. "Significant" in this instance means:
- i) A hospital that serves a significant number of clients under the medical assistance program; significant in this instance means that the hospital qualifies as a disproportionate share hospital (DSH) under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(5); or qualifies as a Medicare DSH hospital under the current federal guidelines.
  - ii) A government-owned facility that meets the cash flow criterion under subsection (h)(1)(A)(ii) ~~of this Section~~.
  - iii) A hospital that has filed for Chapter 11 bankruptcy and that meets the cash flow criterion under subsection (h)(1)(A)(ii) ~~of this Section~~.

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- C) The provider must ensure that a delay of payment request, as defined under subsection (h)(3)(A) ~~of this Section~~, is received by the Department prior to the payment due date, and the request must include a Cash Position Statement that is based upon current assets, current liabilities and other data for a date that is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:
- i) The ratio of current assets divided by current liabilities is greater than 2.0.
  - ii) Cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments that are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.
- D) The provider must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.
- E) The provider must sign an agreement with the Department that specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:
- i) Specific reasons for institution of the delayed payment provisions;
  - ii) Specific dates on which payments must be received and the amount of payment that must be received on each specific date described;
  - iii) The interest or a statement of interest waiver as described in subsection (h)(5) ~~of this Section~~ that shall be due from the provider as a result of institution of the delayed

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payment provisions;

- iv) A certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;
- v) A certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and
- vi) ~~OtherSuch other~~ terms and conditions that may be required by the Department.

2) A hospital that does not meet the above criteria may request a delayed payment schedule. The Department may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

- A) In order to receive consideration for delayed payment provisions, providers must ensure their request is received by the Department prior to the payment due date, in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the date designated by the Department. Providers will be notified, in writing, as to the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:
  - i) An explanation of the circumstances creating the need for

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the delayed payment provisions;

- ii) Supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) ~~of this Section~~, a denial of application to borrow the assessment as defined in subsection (h)(1)(D) ~~of this Section~~ and an explanation of the risk of irreparable harm to the clients; and
  - iii) Specification of the specific arrangements requested by the provider.
- B) The hospital shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.
- 4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) ~~of this Section~~ may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) ~~of this Section~~, ~~thesueh~~ penalties shall be permanently waived for the subject quarter unless the provider fails to meet all of the terms and conditions of the agreement. In the event the provider fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and ~~thesueh~~ penalties shall be fully reinstated.
- 5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) ~~of this Section~~. The interest may be waived by the Department if the facility's current ratio, as described in subsection (h)(1)(C) ~~of this Section~~, is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B) ~~of~~

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~~this Section~~. Any ~~such~~ waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) ~~of this Section~~.

- 6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delayed payment agreement. The waiver of penalties described in subsection (h)(4) ~~of this Section~~ shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

- i) Administration and Enforcement Provisions

The Department shall establish and maintain a listing of all hospital providers appearing in the licensing records of the Department of Public Health, which shall show each provider's name and principal place of business and the name and address of each hospital operated, conducted, or maintained by the provider in this State. The Department shall administer and enforce ~~Sections 305 ILCS 5/5A-1, 2, 3, 4, 5, 7, 8, 10 and 12~~ of the Code and collect the assessments and penalty assessments imposed under ~~Sections 305 ILCS 5/5A-2 and 4~~ of the Code. The Department, its Director, and every hospital provider subject to assessment measured by occupied bed days shall have the following powers, duties, and rights:

- 1) The Department may initiate either administrative or judicial proceedings, or both, to enforce the provisions of ~~Sections 305 ILCS 5/5A-1, 2, 3, 4, 5, 7, 8, 10 and 12~~ of the Code. Administrative enforcement proceedings initiated shall be governed by the Department's rules at 89 Ill. Adm. Code 104.200 through 104.330. Judicial enforcement proceedings initiated shall be governed by the rules of procedure applicable in the courts of this State.
- 2) No proceedings for collection, refund, credit, or other adjustment of an assessment amount shall be issued more than three years after the due date of the assessment, except in the case of an extended period agreed to in writing by the Department and the hospital provider before the expiration of this limitation period.
- 3) Any unpaid assessment under ~~Section 305 ILCS 5/5A-2~~ of the Code shall

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become a lien upon the assets of the hospital upon which it was assessed. If any hospital provider, outside the usual course of its business, sells or transfers the major part of any one or more of the real property and improvements, the machinery and equipment, or the furniture or fixtures of any hospital that is subject to the provisions of ~~Sections 305 ILCS 5/5A-1, 2, 3, 4, 5, 7, 8, 10 and 12~~ of the Code, the seller or transferor shall pay the Department the amount of any assessment, assessment penalty, and interest (if any) due from it under ~~Sections 305 ILCS 5/5A-2 and 4~~ of the Code up to the date of the sale or transfer. If the seller or transferor fails to pay any assessment, assessment penalty, and interest (if any) due, the purchaser or transferee of ~~the such~~ asset shall be liable for the amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Department a certificate showing that ~~the such~~ assessment, penalty, and interest have been paid or a certificate from the Department showing that no assessment, penalty, or interest is due from the seller or transferor under ~~Sections 305 ILCS 5/5A-2, 4 and 5~~ of the Code.

- 4) Payments under ~~Section 305 ILCS 5/5A-4~~ of the Code are not subject to the Illinois Prompt Payment Act [~~30 ILCS 540~~]. Credits or refunds shall not bear interest.
- 5) In addition to any other remedy provided for and without sending a notice of assessment liability, the Department may collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Department to the hospital provider.

j) Exemptions

The following classes of providers are exempt from the assessment imposed under ~~Section 305 ILCS 5/5A-4~~ of the Code unless the exemption is adjudged to be unconstitutional or otherwise invalid:

- 1) A hospital provider that is a State agency, a State university, or a county with a population of 3,000,000 or more.

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- 2) A hospital provider that is a county with a population of less than 3,000,000 or a township, municipality, hospital district, or any other local governmental unit.
  - 3) For State fiscal years 2004 through 2014 and the portion of State fiscal year 2015 that ends December 31, 2014, a hospital provider, described in section 1903(w)(3)(F) of the Social Security Act, whose hospital does not charge for its services is exempt from the assessment imposed by Section 5A-2 of the Public Aid Code.
  - 4) For State fiscal years 2004 and 2005, a hospital provider whose hospital is licensed by the Department of Public Health as a psychiatric hospital.
  - 5) For State fiscal years 2004 and 2005, a hospital provider whose hospital is licensed by the Department of Public Health as a rehabilitation hospital.
  - 6) For State fiscal years 2004 and 2005, a hospital provider whose hospital is not a psychiatric hospital, rehabilitation hospital, or a children's hospital and has an average length of inpatient stay greater than 25 days.
- k) Nothing in Section 305 ILCS 5/5A-4 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before February 3, 2004.
- l) Definitions.  
As used in this Section, unless the context requires otherwise:
- 1) "Adjusted gross hospital revenue for inpatient services" means inpatient gross revenue less Medicare gross inpatient revenue, which shall be determined using the most recent data available from each hospital's 2003 Medicare cost report as contained in the HCRIS file for the quarter ending December 31, 2004, without regard to any subsequent adjustments or changes to that data.
  - 2) "Adjusted gross hospital revenue for outpatient services" means outpatient gross revenue less Medicare gross outpatient revenue, which shall be determined using the most recent data available from each hospital's 2003 Medicare cost report as contained in the HCRIS file for the quarter ending December 31, 2004, without regard to any subsequent adjustments or

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changes to such data.

- 3) "CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.
- 4) "Department" means the Illinois Department of Healthcare and Family Services.
- 5) "Fund" means the Hospital Provider Fund.
- 6) "HCRIS" means the federal Centers for Medicare and Medicaid Services Healthcare Cost Report Information System.
- 7) "Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.
- 8) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.
- 9) "Inpatient Gross Revenue" means total inpatient gross revenue, as reported on the HCRIS Worksheet C, Part 1, Column 6, Line 101, less the sum of the following lines (including any subset lines of these lines):
  - A) Line 34: Skilled Nursing Facility.
  - B) Line 35: Other Nursing Facility.
  - C) Line 35.01: Intermediate Care Facility for the Mentally Retarded.
  - D) Line 36: Other Long Term Care.

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- E) Line 45: PBC Clinical Laboratory Services – Program Only.
  - F) Line 60: Clinic.
  - G) Line 63: Other Outpatient Services.
  - H) Line 64: Home Program Dialysis.
  - I) Line 65: Ambulance Services.
  - J) Line 66: Durable Medical Equipment – Rented.
  - K) Line 67: Durable Medical Equipment – Sold.
  - L) Line 68: Other Reimbursable.
- 10) "Medicare bed days" means, for each hospital, the sum of the number of days that each bed was occupied by a patient who was covered by Title XVIII of the Social Security Act, excluding days attributable to the routine services provided to persons receiving skilled or intermediate long term care services. Medicare bed days shall be computed separately for each hospital operated or maintained by a hospital provider.
- 11) "Medicare Gross Inpatient Revenue" means the sum of the following:
- A) The sum of the following lines from the HCRIS Worksheet D-4, Column 2 (excluding the Medicare gross revenue attributable to the routine services provided to patients in a psychiatric hospital, a rehabilitation hospital, a distinct part psychiatric unit, a distinct part rehabilitation unit or swing beds):
    - i) Line 25: Adults and Pediatrics.
    - ii) Line 26: Intensive Care Unit.
    - iii) Line 27: Coronary Care Unit.
    - iv) Line 28: Burn Intensive Care Unit.

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- v) Line 29: Surgical Intensive Care Unit.
- vi) Line 30: Other Special Care Unit.
- B) From Worksheet D-4, Column 2, the amount from Line 103 less the sum of Lines 60, 63, 64, 66, 67 and 68 (and any subset lines of these lines).
- C) The amount from Worksheet D-6, Part 3, Column 3, Line 53.
- 12) "Medicare Gross Outpatient Revenue" means the amount from the HCRIS Worksheet D, Part V, Line 101, Columns 5, 5.01, 5.02, 5.03 and 5.04 less the sum of Lines 45, 60, 63, 64, 65, 66 and 67 (and any subset lines of these lines).
- 13) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds, excluding beds classified as long term care beds and assessed a licensed bed fee during calendar year 2001. Occupied bed days shall be computed separately for each hospital operated or maintained by a hospital provider.
- 14) "Outpatient Gross Revenue" means the amount from the HCRIS Worksheet C, Part I, Column 7, Line 101 less the sum of lines 45, 60, 63, 64, 65, 66, 67 and 68 (and any subset lines of these lines).

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

## SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

**Section 140.402 Copayments for Noninstitutional Medical Services**

The following implements cost sharing in compliance with 42 USC 1396o (section 1916 of the Social Security Act):

- a) Effective July 1, ~~2012~~2003, each recipient, with the exception of those classes of recipients identified in subsection (d) of this Section, ~~shall~~may be required to pay a copayment of \$2.00 for generic legend drugs and over-the-counter drugs billed to the Department, and for other services, with the exception of those services identified in subsection (e), the nominal copayment amount as defined at 42 CFR

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447.54. For dates of service beginning July 1, 2012 through March 31, 2013 the nominal copayment amount is \$3.65. Beginning with dates of service on April 1, 2013, the nominal copayment amount is \$3.90. Specific copayment amounts are described and updated on the Department's Web site for the following specified copayment for noninstitutional medical services:

- 1) Office visits to enrolled practitioners for services reimbursed under the Public Aid Code. Each office visit to a chiropractor, podiatrist, optometrist, or a physician licensed to practice medicine in all its branches billed to the Department, with the exception of those office visits for services identified in subsection (e) of this Section, may require a copayment of \$2.00.
  - 2) Each brand name legend drug billed to the Department, ~~with the exception of drugs identified in subsection (e) of this Section, may require a copayment of \$3.00.~~
  - 3) Each encounter billed to the Department by an Encounter Rate Clinic (ERC), Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), but excluding behavioral services provided by these facilities. For dates of service beginning July 1, 2013, copayments for behavioral health services provided by these facilities are no longer excluded and shall be required to be paid by recipients with the exception of those classes of recipients identified in subsection (d).
- b) In each instance where a copayment is payable, the Department will reduce the amount payable to the affected provider by the respective amount of the required copayment.
- c) No provider of services listed in subsection (a) ~~of this Section~~ may deny service to an individual who is eligible for service on account of the individual's inability to pay the cost of a copayment.
- d) The following individuals receiving medical assistance are exempt from the copayment requirement set forth in subsection (a) ~~of this Section~~:
- 1) Pregnant women, including a postpartum period of 60 days.
  - 2) Children under 19 years of age.

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- 3) All noninstitutionalized individuals whose care is subsidized by the Department of Children and Family Services or the Department of Corrections.
  - 4) Hospice patients.
  - 5) Individuals residing in hospitals, nursing facilities, and intermediate care facilities for the developmentally disabled who, as a condition of receiving services, are required to pay all of their income, except an authorized protected amount for personal use, for the cost of their care. For the purpose of this subsection (d)(5), the protected amount shall be no greater than the protected amount authorized for personal use under 89 Ill. Adm. Code 146.225(c).mentally retarded.
  - 6) Residents of a State-certified, State-licensed, or State-contracted residential care program where residents, as a condition of receiving care in that program, are required to pay all of their income, except an authorized protected amount for personal use, for the cost of their residential care program. For the purpose of this subsection (d)(6), the protected amount shall be no greater than the protected amount authorized for personal use under 89 Ill. Adm. Code 146.225(c).
  - 7) Individuals enrolled in the "Health Benefits for Person with Breast or Cervical Cancer" program under 89 Ill. Adm. Code 120.500.
  - 8) American Indians or Alaskan Natives.
- e) The following medical services are exempt from any copayments:
- 1) Renal dialysis treatment.
  - 2) Radiation therapy.
  - 3) Cancer chemotherapy.
  - 4) Insulin~~Use of insulin.~~
  - 5) Services for which Medicare is the primary payer.

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- ~~6)~~ ~~Over-the-counter drugs.~~
- ~~6)7)~~ Emergency services as defined at 42 USC 1396u-2(b)(2) (section 1932(b)(2) of the Social Security Act) and 42 CFR 438.114(a)42-CFR 447.53(b)(4).
- ~~7)8)~~ Any pharmacy compounded drugs.
- ~~8)9)~~ Any prescription (legend drug) dispensed or administered by a hospital, clinic or physician.
- ~~9)10)~~ Family planning services and supplies described in 42 USC 1396d(a)(4)(C) (section 1905(a)(4)(C) of the Social Security Act), including contraceptives and other pharmaceuticals for which the State claims or could claim federal match at the enhanced rate under 42 USC 1396b(a)(5) (section 1903(a)(5) of the Social Security Act) for family planning services and supplies.
- ~~10)11)~~ Other therapeutic drug classes as specified by the Department.
- 11) Preventive services as described in section 4106(b) of the Affordable Care Act.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.405 Non-Institutional Rate Reductions~~Senior Care Pharmaceutical Benefit~~  
(Repealed)**

Notwithstanding any provisions to the contrary in this Part, effective for dates of service on or after July 1, 2012, reimbursement rates and other payments to non-institutional providers shall be reduced by an additional 2.7% from the rates or payments that were otherwise in effect on June 30, 2012, except that the reductions shall not apply to:

- a) Rates or payments for physician services, dental services, services reimbursed through an encounter rate, services provided under the Medicaid Rehabilitation Option of the Illinois Title XIX State Plan.
- b) Rates or payments, or the portion thereof, paid to a provider that is operated by a

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unit of local government or State University that provides some or all of the non-federal share of the services.

c) Pharmacy services, which are reduced pursuant to Sections 140.414 and 140.445.

(Source: Old Section repealed at 30 Ill. Reg. 10370, effective May 26, 2006, and new Section added at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.413 Limitation on Physician Services**

- a) When provided in accordance with the specified limitations and requirements, the Department shall pay for the following services:
- 1) Termination of pregnancy – only in those cases in which the physician has certified in writing to the Department that the procedure is necessary to preserve the life of the mother. All claims for reimbursement for abortions or induced miscarriages or premature births must be accompanied by the physician's written certification that the procedure is necessary for preservation of the life of the woman, or that the induced premature birth was to produce a live viable child and was necessary for the health of the mother or her unborn child.
  - 2) Sterilization
    - A) Therapeutic sterilization – only when the procedure is either a necessary part of the treatment of an existing illness, or is medically indicated as an accompaniment of an operation on the female genitourinary tract. Mental incapacity does not constitute an illness or injury that would authorize this procedure.
    - B) Nontherapeutic sterilization – only for recipients age 21 or older and mentally competent. The physician must obtain the recipient's informed written consent in a language understandable to the recipient before performing the sterilization and must advise the recipient of the right to withdraw consent at any time prior to the operation. The operation shall be performed no sooner than 30 days and no later than 180 days following the date of the recipient's written informed consent, except in cases of premature delivery or emergency abdominal surgery. An individual may

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consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent was given.

- 3) Effective October 1, 2012, surgery ~~Surgery~~ for morbid obesity ~~is covered~~ only with prior approval by the Department. The Department shall approve payment for this service only in those cases in which the physician determines that obesity is exogenous in nature, the recipient has had the benefit of other therapy with no success, endocrine disorders have been ruled out, and the body mass index (BMI) is 40 or higher, or 35 to 39.9 with serious medical complications. The medical record must contain the following documentation of medical necessity:
- A) Documentation of review of systems (history and physical);
  - B) Client height, weight and BMI;
  - C) Listing of co-morbidities;
  - D) Patient participation in a six month consecutive medically supervised weight loss program working in conjunction with a registered dietician and or physician within two years prior to the surgery, with at least four documented visits within the consecutive six months; ~~weight loss attempts;~~
  - E) Current and complete psychiatric evaluation indicating the patient is an appropriate candidate for weight loss surgery; and
  - F) Documentation of nutritional counseling.
- 4) Psychiatric services
- A) Treatment – when the services are provided by a physician who has been enrolled as an approved provider with the Department. ~~Psychiatric treatment services are not covered services for recipients of General Assistance.~~
  - B) Consultation – only when necessary to determine the need for psychiatric care. Services provided subsequent to the initial

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consultation must comply with the requirements for treatment.

- C) Group Psychotherapy – payment may be made for up to two group sessions per week, with a maximum of one session per day. The following conditions must be met for group psychotherapy:
- i) documentation maintained in the patient's medical record must indicate the person participating in the group session has been diagnosed with a mental illness as defined in the International Classification of Diseases (ICD-9-CM) or the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). The allowable diagnosis code ranges will be specified in the Handbook for Practitioners Rendering Medical Services~~Physicians~~; and
  - ii) beginning 1/1/10, the entire group psychotherapy service is directly performed by a physician licensed to practice medicine in all its branches who has completed an approved general psychiatry residency program or is providing the service as a resident or attending physician at an approved or accredited residency program; and
  - iii) the group size does not exceed 12 patients, regardless of payment source; and
  - iv) the minimum duration of a group session is 45 minutes; and
  - v) the group session is documented in the patient's medical record by the rendering physician, including the session's primary focus, level of patient participation, and begin and end times of each session; and
  - vi) the group treatment model, methods, and subject content have been selected on evidence-based criteria for the target population of the group and follows recognized practice guidelines for psychiatric services; and

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- vii) the group session is provided in accordance with a clear written description of goals, methods and referral criteria; and
  - viii) ~~Effective July 1, 2012, group psychotherapy is not covered for recipients who are residents in a facility licensed under the Nursing Home Care Act [210 ILCS 45] or the Specialized Mental Health Rehabilitation Act [210 ILCS 48], if the patient is a resident of a long term care facility, the provider of the group psychotherapy must maintain documentation in the patient's medical record demonstrating the coordination of services and the sharing with the long term care facility of information related to the patient's needs and the implementation and effectiveness of the patient's plan of care.~~
- 5) Services provided to a recipient in his or her home – only when the recipient is physically unable to go to the physician's office.
  - 6) Services provided to recipients in group care facilities by a physician other than the attending physician – only for emergency services provided when the attending physician of record is not available or when the attending physician has made referral with the recipient's knowledge and permission.
  - 7) Services provided to recipients in a group care facility by a physician who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit in the facility) – only when occasioned by an emergency due to acute illness or unavailability of essential treatment facilities in the vicinity for short-term care pending transfer, or when there is no comparable facility in the area.
  - 8) Maternity care – Payment shall be made for pre-natal and post-natal care only when the following conditions are met:
    - A) the physician, whether based in a hospital, clinic or individual practice, retains hospital delivery privileges, maintains a written referral arrangement with another physician who retains such privileges, or has been included in the Maternal and Child Health

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- Program as a result of having entered into an appropriate Healthy Moms/Healthy Kids Program provider agreement;
- B) the written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; and
  - C) maternal services are delivered in a manner consistent with the quality of care guidelines published by the American College of Obstetricians and Gynecologists in the current edition of the "Standards for Obstetric-Gynecologic Services" (1989 Edition), 409 12<sup>th</sup> Street, S.W., Washington, D.C. 20024-2188.
- 9) Physician services to children under age 21
- A) Payment shall be made only when the physician meets one or more of the following conditions. The physician:
    - i) has admitting privileges at a hospital; or
    - ii) is certified or is eligible for certification in pediatrics or family practice by the medical specialty board recognized by the American Board of Medical Specialties; or
    - iii) is employed by or affiliated with a Federally Qualified Health Center; or
    - iv) is a member of the National Health Service Corps; or
    - v) has been certified by the Secretary of the Department of Health and Human Services as qualified to provide physician services to a child under 21 years of age; or
    - vi) has current, formal consultation and referral arrangements with a pediatrician or family practitioner for the purposes of specialized treatment and admission to a hospital. The written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; or

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- vii) has entered into a Maternal and Child Health provider agreement or has otherwise been transferred in from the Healthy Moms/Healthy Kids Program;
  - B) The physician shall certify to the Department the way in which he or she meets the above criteria; and
  - C) Services to children shall be delivered in a manner consistent with the standards of the American Academy of Pediatrics and rules published by the Illinois Department of Public Health (77 Ill. Adm. Code 630, Maternal and Child Health Services; 77 Ill. Adm. Code 665, Child Health Examination Code; 77 Ill. Adm. Code 675, Hearing Screening; 77 Ill. Adm. Code 685, Vision Screening).
- 10) Hysterectomy – only if the individual has been informed, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing and the individual has signed a written acknowledgment of receipt of the information. The Department will not pay for a hysterectomy that would not have been performed except for the purpose of rendering an individual permanently incapable of reproducing.
- 11) Selected surgical procedures, including:
  - A) Tonsillectomies or Adenoidectomies
  - B) Hemorrhoidectomies
  - C) Cholecystectomies
  - D) Disc Surgery/Spinal Fusion
  - E) Joint Cartilage Surgery/Meniscectomies
  - F) Excision of Varicose Veins
  - G) Submucous Resection/Rhinoplasty/Repair of Nasal System
  - H) Mastectomies for Non-Malignancies

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- I) Surgical procedures that generally may be performed in an outpatient setting (see Section 140.117) only if the Department authorizes payment. The Department will in some instances require that a second physician agree that the surgical procedure is medically necessary prior to approving payment for one of these procedures. The Department will require a second opinion when the attending physician has been notified by the Department that he or she will be required to obtain prior approval for payment for the surgeries listed. (See Sections 140.40 through 140.42 for prior approval requirements.) The Department will select physicians for this requirement based on the recommendation of a peer review committee that has reviewed the utilization pattern of the physician.
- 12) Mammography screening
  - A) Covered only when ordered by a physician for screening by low-dose mammography for the presence of occult breast cancer under the following guidelines:
    - i) a baseline mammogram for women 35 through 39 years of age; and
    - ii) a mammogram once per year for women 40 years of age or older.
  - B) As used in this subsection (a)(12), "low-dose mammography" means the x-ray examination of the breast using equipment specifically designated for mammography that will meet appropriate radiological standards.
- 13) Pap tests and prostate-specific antigen tests – coverage is provided for the following:
  - A) An annual cervical smear or Pap smear test for women.
  - B) An annual digital rectal examination and a prostate-specific antigen test, upon the recommendation of a physician licensed to

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practice medicine in all its branches, for:

- i) asymptomatic men age 50 and over;
- ii) African-American men age 40 and over; and
- iii) men age 40 and over with a family history of prostate cancer.

14) [Effective July 1, 2012, coronary artery by-pass grafts are covered only with prior approval by the Department.](#)

- b) In cases in which a physical examination by a second physician is needed, the Department will notify the recipient and designate a physician to perform the examination. Physicians will be subject to this requirement for six months, after which a request can be submitted to the peer review committee to consider removal of the prior approval requirement.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items – Prescribers**

For the purpose of this Section, "prescriber" shall mean any person who, within the scope of his or her professional licensing requirements, may prescribe or dispense drugs.

- a) Prescriptions
  - 1) A prescriber may prescribe any pharmacy item, not otherwise excluded, that, in the prescriber's professional judgment, is essential for the diagnosis or accepted treatment of a recipient's present symptoms. The Department may require prior approval of any drug except as outlined in Section 140.442(a)(9).
  - 2) A prescriber shall:
    - A) Use a tamper-resistant prescription form, as defined at Section 140.443(b)(2), for non-electronic prescriptions. Non-electronic prescriptions are defined at Section 140.443(b)(1). In addition, the

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prescriber shall ensure the prescription form is compliant with Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23); and

- B) Enter on the form all data elements required under Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23), as well as one of the following data elements identifying the prescriber:
- i) Drug Enforcement Administration (DEA) Number; or
  - ii) National Provider Identifier (NPI); or
  - iii) Medical Assistance Program Provider Number; or
  - iv) Illinois State License Number.
- 3) The prescriber shall not charge for writing a prescription.
- 4) Items that shall not be prescribed are listed in Section 140.441.
- b) Dispensed Items
- 1) A participating prescriber may dispense pharmacy items subject to the Department's coverage policies. The prescriber shall not charge for any samples dispensed or anesthesia agents administered for office surgical procedures.
  - 2) Effective ~~July 1, 2012~~February 1, 2012, the Department shall pay for covered outpatient drug items dispensed or administered by a non-pharmacy provider at a rate equal to the lowest of the provider's usual and customary charge to the public; or
    - A) The Average Sales Price (ASP) plus 6 percent. ASP means the ASP as defined in the Social Security Act, Title XVIII, section 1847A(c) (42 USC 1395 w-3a(c)) and calculated by the federal Centers for Medicare and Medicaid Services (CMMS); or
    - B) The State upper limit.

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~~3)B)~~ Effective July 1, 2012, in ~~the~~ cases in which ASP is not available and no State upper limit has been developed, the Department's lowest maximum allowable price for all covered NDCs assigned to the HCPCS billing code (the methodology for determining the Department's maximum prescription prices is specified in Section 140.445(b)(1) and (b)(2)).

~~4)3)~~ Reimbursement rates for drugs dispensed or administered by non-pharmacy providers shall be updated no less frequently than twice per calendar year.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.417 Limitations on Optometric Services**

Payment for the following optometric services and materials shall be made subject to the following limitations:

- a) Payment shall be made for single vision lenses only when the following conditions are met:
  - 1) The power is at least 0.75 diopters in either the sphere or cylinder component; or
  - 2) The difference between the old and new prescription is at least 0.75 diopters in either the sphere or cylinder component.
- b) Payment shall be made for bifocal lenses only when the following conditions are met:
  - 1) For first bifocals, the power of the bifocal addition is at least 1.00 diopter.
  - 2) For a change in bifocal lenses, the power of the bifocal addition is changed by at least 0.50 diopters or the distance power represents a change of at least 0.75 diopters.
- c) Payment shall be made for more than one examination per year only when the vendor documents the need for the additional examination.

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- d) Effective July 1, 2012, payment shall be made for one pair of eyeglasses or set of lenses for adults in a 24-month period. Payment shall be made for more than one pair of eyeglasses or set of lenses per year for children through age 20 only when the physician or optometrist documents:
- 1) that:
    - A) the most recent pair of eyeglasses or set of lenses was lost or destroyed for reasons beyond the control of the recipient; or
    - B) there is a change in the prescription that meets the requirements in subsection (a)(2) or (b)(2) ~~of this Section~~; and
  - 2) that the additional pair is medically necessary.
- e) Payment for optometric materials dispensed by a supplier other than a physician or optometrist, except for replacement and repair items, shall be made only when they are prescribed by a licensed physician or optometrist.
- f) Effective July 1, 2012, prior ~~Prior~~ approval pursuant to Section 140.40 is required for the services and materials described in this subsection (f). Approval shall be given when, in the judgment of a Department consultant, the requested item or service is appropriate.
- 1) Contact lenses and related contact lens services;
  - ~~2) A third pair of eyeglasses in one year for adults 21 years of age or older;~~
  - ~~2)3)~~ Custom made artificial eyes;
  - ~~3)4)~~ Low vision devices; and
  - ~~4)5)~~ Any item or service not specifically included in the schedule of procedures for optical services and supplies.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.420 Dental Services**

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- a) Payment for dental services shall be made only to enrolled licensed dentists. Payment for comprehensive orthodontic care shall be made only to a dentist licensed for provision of ~~those such~~ services.
- b) Effective July 1, 2012, except ~~Except as for the "services not covered" specified in subsections subsection (c) and (d) of this Section,~~ payment shall be made for covered dental services as described in subsections (b)(1) and (b)(2) and as listed in Table D that are:
- 1) Necessary to relieve pain or infection, preserve teeth, or restore adequate dental function;
  - 2) Diagnostic, preventive, or restorative services, endodontics, prosthodontics, orthodontics or oral surgery included in the Department's Schedule of Dental Procedures (see Table D ~~of this Part~~); and
  - 3) Performed by the dentist or under the direct supervision of the dentist.
- c) Payment~~Services for which payment~~ shall not be made for experimental dental care and procedures performed only for cosmetic reasons.~~include:~~
- 1) ~~Routine or periodic examinations other than clinical oral examinations (see Table D(a)(1));~~
  - 2) ~~Experimental dental care;~~
  - 3) ~~Procedures performed only for cosmetic reasons;~~
  - 4) ~~Dental prophylaxis for individuals 21 years and older;~~
  - 5) ~~Topical fluoride treatment and sealants for individuals age 21 years and older;~~
  - 6) ~~Space maintainers for individuals age 21 years and older;~~
  - 7) ~~Acrylic crown;~~
  - 8) ~~Prefabricated stainless steel crown for primary tooth for individuals age 21 years and older;~~

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- ~~9) Therapeutic pulpotomy for individuals age 21 years and older;~~
  - ~~10) Bicuspid and molar root canals, apexification, and apicoectomy procedures for anterior teeth, bicuspids, and permanent first molars for individuals age 21 years and older;~~
  - ~~11) Periodontics for individuals age 21 years and older;~~
  - ~~12) Partial dentures for adults age 21 years and older;~~
  - ~~13) All dentures placed prior to five year expiration (see Section 140.421(c));~~
  - ~~14) Bridgework for individuals age 21 years and older;~~
  - ~~15) Surgical exposure to aid eruption for individuals age 21 years and older;~~
  - ~~16) Alveoloplasty for individuals age 21 years and older;~~
  - ~~17) Frenulectomy for individuals age 21 years and older; and~~
  - ~~18) Orthodontics for individuals age 21 years and older.~~
- d) Effective for dates of service on or after July 1, 2012, notwithstanding other provisions of this Section or Section 140.421, dental services rendered to recipients age 21 years and older shall be limited to those dental services that are medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury that can be treated by extraction and dental services that are medically necessary as a prerequisite for necessary medical care.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.425 Podiatry Services**

- a) Payment for podiatry services shall be made only to licensed podiatrists.
- b) Effective July 1, 2012, payment ~~Payment~~ shall be made for those podiatric services provided to recipients under the age of 21 or recipients age 21 and over who have been diagnosed with diabetes as defined in the International

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Classification of Diseases. The allowable diagnosis code ranges will be specified in the Handbook for Providers of Podiatric Services.~~that are:~~

c) Effective July 1, 2012, payment shall be made for those podiatric services that are:

1) Limited to recipients under the age of 21 or recipients age 21 and over who have been diagnosed with diabetes as defined in the International Classification of Diseases.

21) Essential for the diagnosis and treatment of conditions of the feet.

32) Listed in the Current Procedural Terminology (CPT) for podiatric office visits, diagnostic radiology, pathology, or orthomechanical procedures included in the Department's schedule of podiatric services.

43) Performed by the podiatrist or under the direct supervision of the podiatrist.

54) Routine foot care services (trimming of nails, treatment of calluses, corns, and similar services) when a participant is under active treatment for diabetes mellitus, ~~or has a systemic condition that has resulted in severe circulatory impairment or an area of desensitization in the legs or feet and a routine type of foot care is required. These services may not be provided at less than 60 day intervals.~~

de) Payment shall not be made for the following services:

1) Making a referral, obtaining a specimen, handling a specimen for analysis, or ordering a laboratory test~~;~~

2) Visits and services provided to recipients eligible for Medicare benefits if the services are determined not medically necessary by Medicare~~;~~

3) Services provided to recipients in group care facilities by a podiatrist who derives direct or indirect profit from total or partial ownership of the facility~~;~~

4) Routine foot care, except as described in subsection (c)~~(b)~~(54)~~;~~ ~~of this~~

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- 5) ~~Screening for foot problems;~~
- 6) ~~Provider transportation costs;~~
- 7) ~~X-rays, and laboratory procedures performed at a location other than the podiatrist's own office;~~
- 8) ~~X-rays, laboratory work or similar services not specifically required by the condition for which the recipient is being treated;~~
- 9) Routine post-operative visits.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.428 Chiropractic Services**

- a) Payment shall be made only to chiropractors.
- ~~b) Effective July 1, 2012, payment shall only be made for chiropractic services provided to recipients under the age of 21.~~
- ~~cb) Payment shall be made for only one chiropractic service: manual manipulation of the spine to correct a subluxation of the spine which has resulted in a neuromusculoskeletal condition for which ~~thesuch~~ manipulation is an appropriate treatment.~~

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.440 Pharmacy Services**

- a) Payment shall be made only to pharmacies.
- b) The following conditions apply to pharmacy participation:
  - 1) The pharmacy must hold a current Drug Enforcement Administration (DEA) registration issued by the United States Drug Enforcement Administration (see 21 CFR 1301 et seq.), as well as a current controlled

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substances license issued by the Illinois Department of Financial and Professional Regulation (see Controlled Substances Act [720 ILCS 570]) prior to enrolling with the Department.

## 2) Licensed Pharmacy Requirements

A) A licensed pharmacy located in and/or administratively associated with a group practice or long-term facility must:

- i) provide the same scope of general pharmacy and professional services as a pharmacy not so affiliated; and
- ii) be retail in nature, open and accessible to the general public.

B) The pharmacy shall not limit prescriptions filled to those written by practitioners connected with the group or facility for persons receiving care or services from the group or facility.

3) A hospital pharmacy ~~that~~which provides pharmaceutical services and supplies for inpatients, outpatient clinic patients and emergency room patients of the hospital may not enroll as a participating pharmacy unless licensed to provide pharmaceutical services to the general public (Division 5 license).

4) Effective August 1, 2012, in order to dispense blood factor, a pharmacy must sign a standards of care agreement with the Department.

5) A pharmacy billing the Department for 340B-purchased drugs shall charge the Department no more than the 340B entity's actual acquisition cost (AAC) for the drug product plus the Department's established dispensing fee, unless the Department has calculated an allowable amount specific to 340B-purchased drugs for that drug. In that case, the pharmacy may bill the Department its usual and customary charges. For a pharmacy provider owned or operated by a Hemophilia Treatment Center, this requirement does not become effective until July 1, 2013.

c) The Department shall pay for the dispensing of pharmacy items, subject to the provisions of subsection (d) ~~below~~ and Section 140.443, which are prescribed by

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a physician, dentist or podiatrist within the scope of their professional practice.

- d) Beginning with drugs dispensed on or after April 1, 1991, Department coverage shall be limited to those drug manufacturers having rebate agreements in effect as provided under Section 1927 of Title XIX of the Social Security Act (42 ~~USC~~U.S.C. 1396s). The Department shall provide all interested parties with an updated list of drug manufacturers having rebate agreements in effect.
- e) The Department may require approval for the reimbursement of any drug except as provided in Section 140.442. When reviewing requests for prior authorization, approval decisions shall be medically based. The Department's electronic claims processing system shall be the mechanism for identification of whether a prescribed drug requires prior authorization to dispensing pharmacists. A printed listing of prescribed drugs available without prior approval shall be provided to other interested parties upon request.
- f) An approved request does not guarantee payment. The recipient for whom the services/items are approved must be eligible at the time they are provided. In addition, a valid, current prescription for the requested medication must be on file and maintained by the pharmacy in accordance with the Pharmacy Practice Act of 1987 [225 ILCS 85].
- g) For purposes of Sections 140.440 through 140.448, pertaining to reimbursement for drugs, the following definitions apply:
- 1) Nursing facility means any facility ~~that~~which provides medical group care services as defined in Section 140.500.
  - 2) Generic drug means those legend drugs ~~that~~which are multiple source drugs marketed or sold by two or more labelers, marketed or sold by the same labeler under two or more different proprietary names or marketed both under a proprietary name and without such a name.
  - 3) Brand name drug means single-source innovator drugs and innovator multiple-source drugs when prior authorization has been obtained for reimbursing the innovator product.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

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**Section 140.441 Pharmacy Services Not Covered**

Items excluded from coverage include the following:

- a) Drug products manufactured by drug manufacturers not meeting the rebate requirements of Section 140.440(d);
- b) Anorectic drugs or combinations including such drugs;
- c) Biologicals and drugs available without charge from the Illinois Department of Public Health or other agencies;
- d) Any vaccine, drug or serum which is provided primarily for preventive purposes, e.g., influenza vaccine;
- e) Drugs for injection in a practitioner's office unless the cost of the drug per injection (excluding administration) exceeds \$25.00;
- f) Drugs that have been classified by the Food and Drug Administration (FDA) as ineffective or unsafe in a final order;
- g) Drugs that the Food and Drug Administration has proposed in a notice of opportunity for hearing to withdraw labeled indications (~~f~~pursuant to ~~section~~Section 107(c)(3) of the Drug Amendments of 1962 (P.L. 87-781) and ~~section~~Section 505(e) of the Federal Food, Drug and Cosmetic Act (21 USC 355(e))~~}]~~ and any identical, related or similar drug products (~~f~~determined by the FDA in accordance with 21 CFR 310.6)~~}]~~;
- h) Items identified as Group Care Restricted Items (see Section 140.449(b)) are not covered when provided to recipients living in licensed long-term care facilities;
- i) Sickroom Needs and Medical Equipment Items are not covered as pharmacy items. A pharmacy ~~that~~which desires to provide ~~thesuch~~ items must enroll as a provider of medical equipment; and
- j) Miscellaneous ~~supplies that~~Supplies which are stocked and dispensed by some pharmacies are not covered. These items include, but are not limited to, dental products, hair products, facial tissues, infant disposable diapers, sanitary pads, tampons, soap or other personal hygiene products, proprietary food supplements

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or substitutes, sugar or salt substitutes, household products, or infant formula for routine feeding.

- k) Effective July 1, 2012, blood factor, when a patient has not had a comprehensive examination at a federally-funded Hemophilia Treatment Center during the 365 days preceding the date of service.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.442 Prior Approval of Prescriptions**

- a) The Department may require prior approval for the reimbursement of any drug, except as provided in this Section. Determinations of whether prior approval for any drug is required shall be made in the following manner:
- 1) The Department shall consult with individuals or organizations ~~that~~which possess appropriate expertise in the areas of pharmacology and medicine. In doing so, the Department shall consult with organizations composed of physicians, pharmacologists, or both, and shall, to the extent that it consults with organizations, limit its consultations to organizations which include within their membership physicians practicing in all of the representative geographic areas in which recipients reside and practicing in a majority of the areas of specialization for which the Department reimburses physicians for providing care to recipients.
  - 2) The Department shall consult with a panel from ~~thesueh~~ organizations (the panel is selected by ~~thesueh~~ organizations) to review and make recommendations regarding prior approval. The panel shall meet not less than four times a year for the purpose of the review of drugs. The actions of the panel shall be non-binding upon the Department and can in no way bind or otherwise limit the Department's right to determine in its sole discretion those drugs ~~that~~which shall be available without prior approval.
  - 3) Upon U.S. Food and Drug Administration approval of a new drug, or when post-marketing information becomes available for existing drugs requiring prior approval, the manufacturer shall be responsible for submitting materials to the Department which the Department and the consulting organization shall consider in determining whether reimbursement for the drug shall require prior approval.

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- 4) New dosage strengths and new dosage forms of products currently included in the list of drugs available without prior approval (see Section 140.440(e)) shall be available without prior approval upon the request of the manufacturer, unless otherwise designated by the Director. In such a case, the Director shall submit the new dosage strength, or new form, to the prior approval procedures described in this Section.
- 5) Upon receipt of the final agenda established for each meeting of the panel created under subsection (a)(2), the Department shall promptly review materials and literature supplied by drug manufacturers. Additional literature may be researched by the Department to assist the panel in its review of the products on the agenda. The Department shall make comments and, within ten working days after receipt of the agenda, transmit such comments either in person or in writing to the panel. This shall be done for each meeting of the above described panel.
- 6) The consulting organization shall transmit its recommendations to the Department in writing.
- 7) Upon receipt of this transmittal letter, the Department shall, within 15 business days, notify all interested parties, including pharmaceutical product manufacturers, of all recommendations of the consulting organization accepted or rejected by the Director. Notifications to pharmaceutical manufacturers of the Director's decision to require prior approval shall include reasons for the decision. Decisions requiring prior approval of new drug products not previously requiring prior approval shall become effective no sooner than ten days after the notification to providers and all interested parties, including manufacturers. The Department shall maintain a mailing list of all interested parties who wish to receive a copy of applicable notices.
- 8) Drug manufacturers shall be afforded an opportunity to request reconsideration of products recommended for prior approval. The ~~drug~~Drug manufacturers may submit whatever information they deem appropriate to support their request for reconsideration of the drug product. All reconsideration requests must be submitted in writing to the Department and shall be considered at the next regularly scheduled meetings of the expert panel created under subsection (a)(2) convened by

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the consulting organization.

- 9) ~~Effective July 1, 2012, the~~ Department shall provide that the following types of drugs are available without prior approval:

~~A) Drugs for the treatment of Acquired Immunodeficiency Syndrome (AIDS) which the Federal Food and Drug Administration has indicated is subject to a treatment investigational new drug application;~~

~~AB) Contraceptive drugs and products; and~~

~~C) Oncolytic drugs; and~~

~~BD) Non-innovator products, listed in the State of Illinois Drug Product Selection Program's current Illinois Formulary, when the innovator product is available without prior approval.~~

- b) ~~Prior~~ Except as provided in subsection (c), prior approval shall be given for drugs requiring ~~such~~ authorization if:

- 1) The drug is a legend item (requires a prescription); and
- 2) The drug is used in accordance with predetermined standards consistent with the compendia consisting of the American Hospital Formulary Service Drug Information, the United States Pharmacopeia-Drug Information and the American Medical Association Drug Evaluations, as well as the peer-reviewed medical literature; and
- 3) Either:
  - A) The drug is necessary to prevent a higher level of care, such as institutionalization; or
  - B) The prescriber has determined that the drug is medically necessary.

- ~~e) For recipients covered by the General Assistance Medical Program, prior approval shall be given for drugs requiring such authorization if:~~

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- ~~1) The drug is a legend item (requires a prescription); and~~
- ~~2) The drug is used in accordance with predetermined standards consistent with the compendia consisting of the American Hospital Formulary Service Drug Information, the United States Pharmacopeia Drug Information and the American Medical Association Drug Evaluations, as well as the peer reviewed medical literature; and~~
- ~~3) The physician has documented that the requested item is necessary to prevent a life threatening situation and that items covered under the basic health protection plan are not effective to maintain the patient's life or to avoid the life threatening situation.~~

~~cd)~~ Decisions on all requests for prior approval by telephone or other telecommunications device and, upon the Department's receipt of ~~the~~such request, shall be made by the same time of the Department's next working day. In an emergency situation, the Department shall provide for the dispensing of at least a 72-hour supply of a covered prescription drug.

~~de)~~ In accordance with subsection ~~(d)(e)~~(2), the Department may require prior approval prior to reimbursement for a brand name prescription drug if the patient for whom the drug is prescribed has already received three brand name prescription drugs in the preceding 30-day period; and is 21 years of age or older.

1) For purposes of this subsection ~~(de)~~, brand name prescription drugs in the following therapeutic classes shall not count towards the limit of three brand name prescription drugs and shall not be subject to prior approval requirements because a patient has received three brand name prescription drugs in the preceding 30 days.

- A) Antiretrovirals;
- B) Antineoplastics; and
- C) Anti-Rejection Drugs;;
- ~~D) Antipsychotics;~~
- ~~E) Anticonvulsants;~~

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~~F) Insulin; and~~

~~G) Anti-Hemophilic Factor Concentrates.~~

- 2) Brand name prescription drugs are exempt from the prior approval requirements of this subsection (~~de~~) if:
- A) there are no generic therapies for the condition treated within the same therapeutic drug class; or
  - B) the Department determines that the brand name prescription drug is cost effective.

e) Effective July 1, 2012, the Department may require prior approval prior to reimbursement for a prescription drug if the patient for whom the drug is prescribed has already received four prescription drugs in the preceding 30-day period. For purposes of subsection (d), prescription drugs in the following therapeutic classes shall not count towards the limit of four prescription drugs and shall not be subject to prior approval requirements because a patient has received four prescription drugs in the preceding 30 days:

1) Antiretrovirals;

2) Antineoplastics; and

3) Anti-Rejection Drugs.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.443 Filling of Prescriptions**

- a) The prescription must contain the information required under Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23) and also contain the prescriber's:
- 1) Drug Enforcement Administration (DEA) Number; or
  - 2) National Provider Identifier (NPI); or

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- 3) Medical Assistance Program Provider Number; or
  - 4) Illinois State License Number.
- b) To the extent required by federal law, effective with new prescriptions executed on or after April 1, 2008, for clients covered under Title XIX of the Social Security Act, a non-electronic prescription must be written on a tamper-resistant prescription pad to be eligible for reimbursement. This requirement applies to all prescriptions regardless of whether the Department is the primary payor.
- 1) Non-electronic prescriptions are prescriptions that are not transmitted from the prescriber to the pharmacy via telephone, telefax, electronic prescribing (e-prescribing) mechanism, or other means of electronic transmission.
  - 2) Effective April 1, 2008, a prescription form is considered tamper-resistant when it contains any of the following characteristics and, effective October 1, 2008, to be considered tamper-resistant, a prescription form must contain all of the following characteristics:
    - A) one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank form;
    - B) one or more industry-recognized features to prevent the erasure or modification of information written on the prescription by the prescriber;
    - C) one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.
  - 3) If a patient presents at a pharmacy with a prescription written on a prescription pad that is not tamper-resistant, and the pharmacist contacts the prescriber via telephone, telefax, or other electronic communication device, and the prescriber or the prescriber's agent verifies the validity of the prescription, the prescription is then considered "electronic" and, therefore, exempt from the requirement that the prescription be written on a tamper-resistant pad. In such cases, the pharmacist shall note on the

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original prescription that the prescriber was contacted and the prescriber or the prescriber's agent verified the validity of the prescription.

- 4) If a patient presents at a pharmacy with a non-electronic prescription written on a pad that is not tamper-resistant, and the pharmacist is unable to contact the prescriber or the prescriber's agent to verify the validity of the prescription, and the pharmacist, in using his or her professional judgment, determines that not filling the prescription poses a health risk to the patient, the pharmacist may fill the prescription and the Department will reimburse for the prescription, provided that the patient is eligible for coverage of the drug and provided that the drug is covered by the Department. The pharmacist must obtain from the prescriber or the prescriber's agent a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled.

- c) Pharmacies shall not accept blank, presigned prescription forms.
- d) If a drug is available by generic name and the identical drug is prescribed by trade name, payment will be based on cost of the generic product unless prior authorization has been obtained for reimbursement based upon the innovator product, or unless the Department determines that the innovator product, reimbursed at the brand name pricing methodology, is more cost-effective than the generic equivalent.
- e) The Department shall not pay for dispensed items in excess of the maximum quantity established by the Department, unless prior approval has been granted to dispense an amount in excess of the maximum. The Department shall pay for no more than one month's supply of the item dispensed.
- f) The Department shall pay for refills only if the prescribing practitioner authorized refills on the original prescription in accordance with State law.
- g) Pharmacies may use a unit dose system in the dispensing of drugs when such a system is in compliance with all applicable State and ~~federal~~Federal laws. The total quantity dispensed on one prescription cannot exceed the quantity prescribed or the maximum allowable quantity.
- h) Effective January 1, 2013, brand-name, solid, oral drugs dispensed to clients

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residing in any facility that provides medical group care services as defined in Section 140.500, except Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), must be dispensed in 14-day supplies. Exceptions: Solid oral doses of antibiotics and drugs that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance (for example, oral contraceptives), may be dispensed in supplies for greater than 14 days.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.445 Legend Prescription Items (Not Compounded)**

~~Effective February 1, 2012, for legend (prescription) drugs, the Department shall pay the lower of:~~

- a) Effective July 1, 2012, for legend (prescription) drugs, the Department shall pay the lower of:
- 1) the pharmacy's usual and customary charge to the general public; ~~or~~
  - 2b) the Department's maximum price plus the established dispensing fee of ~~\$5.50~~\$6.35 for generic drugs and ~~\$2.40~~\$3.40 for brand name drugs. The Department shall pay only one dispensing fee per 30 days' supply for those drugs dispensed in accordance with Section 140.443(h);~~If the generic dispensing rate during the quarter ending June 30, 2014 is not 2% higher than the generic dispensing rate during the quarter ending December 31, 2011, then effective January 1, 2015, the dispensing fee shall be \$4.60 for generic drugs and \$3.40 for brand name drugs.~~
  - 31) For generic drugs, the Department's maximum price is calculated as the lowest of:
    - A) Wholesale Acquisition Cost (WAC); or Suggested Wholesale Price (SWP) minus 25%; or
    - B) the Federal upper limit as established under section 1927(e)(4) of the Social Security Act (42 USC 1396r-8(e)(4)); or

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- C) the State upper limit; ~~or-~~
- ~~42)~~ For brand name drugs, the Department's maximum price is calculated as the ~~lower~~lowest of:
- A) WAC ~~plus 1%~~; or
- B) the State upper limit.
- b) Effective February 1, 2013, for generic and brand name drugs purchased under the federal drug pricing program established under Section 340B of the federal Public Health Services Act, the Department shall pay the actual acquisition cost for the drug, as billed by the provider, or the Department's established 340B allowable reimbursement rate for the drug, plus a dispensing fee of \$12.00 for brand and generic drugs.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.449 Payment of Pharmacy Items**

- a) The Department shall pay no more for charges submitted than the maximum permitted by ~~federal~~Federal regulations.
- b) Explanation of ~~Drug Restrictions~~drug restrictions
- 1) Group Care ~~and General Assistance~~-Restricted – The drug is available to all recipient categories except ~~recipients of General Assistance and~~ individuals residing in a nursing home.
- 2) The nursing home must provide the following listed drugs to resident recipients at no charge to the recipient:
- Acetaminophen Drops 80mg/0.8ml
- Acetaminophen Drops 120mg/2.5ml
- Acetaminophen Elixir/Syrup 120mg/5ml
- Acetaminophen Tab/Cap 325mg

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Acetaminophen Tab/Cap 500mg

Acetaminophen Tab/Cap 650mg

Acetaminophen Tablet Chewable 80mg

Acetaminophen Tablet Chewable 120mg

Aspirin Tab Buffered 325mg

Aspirin Tab Buffered 600mg

Aspirin Tab EC 300mg

Aspirin Tab EC 600mg

Aspirin Tab Pediatric

Aspirin Tab 300mg

Aspirin Tab 600mg

Glucola Liquid

Milk of Magnesia Liquid

Milk of Magnesia Tablet

Zinc Oxide Ointment

- | c) No restrictions – The drug is available to all recipient categories, including nursing home residents and recipients of basic health coverage.
- d) Group Care Restricted – The drug is available to all recipients except recipients residing in nursing homes. The nursing home must provide the following listed items to resident recipients at no charge to the recipient:

Acetest Reagent Tablets

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Albustix Strips

Chemstrip BG Strips

Chemstrip GP Chemstrip K Papers

Chemstrip Test Kit

Chemstrip UG Strips

Chemstrip UGK Strips

Chemstrip 5

Clinistix Strip

Clinitest (2 Drop)

Clinitest Analysis Set

Clinitest Analysis Set (2 Drop)

Clinitest Tablet

Clinitest Tablet Foil

Combistix

Dextrostix Reagent Strips

Dextrostix Reagent Strips Foil

Diascan Dual Pad Strips

Diastix Strips

Exactech Test Strips

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Glucofilm Test Strips

Glucoscan Test Strips

Glucostix Strips

Hema-Combistix

Hemastix Strips

Hematest Tablet

Keto-Diastix

Keto-Diastix 5

Ketostix Strips

Labstix

Lancet for Diabetic Use, Sterile

N-Uristix

One Touch Test Strips

TES-Tape

Tracer BG Strips

Trendstrips

Uristix

Visidex II Reagent Strips

Any product equivalent to those on the above list or any other nonlisted diabetic testing supply

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- e) Group care limited – The drug is available only to recipients residing in nursing homes.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.457 Therapy Services**

~~Therapy Covered Services: Effective July 1, 2012, physical~~ Physical, occupational and speech/language services are provided for clients because of illness, disability or infirmity and in accordance with a plan established by a physician and reviewed by the physician every 90 days with a maximum of 20 visits allowed per discipline per State fiscal year for adults age 21 and over. Payment may be made for therapy services provided by:

- a) A physical, speech or occupational therapist who is qualified as follows:
- 1) A physical therapist must be licensed by the Department of Financial and Professional Regulation.
  - 2) A speech/language therapist must be licensed by the Illinois Department of Financial and Professional Regulation.
  - 3) An occupational therapist must be licensed by the Department of Financial and Professional Regulation.
- b) A community health agency.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.458 Prior Approval for Therapy Services**

- a) Effective July 1, 2012, prior ~~Prior~~ approval is required for the provision of services by an independent speech/language, physical or occupational therapist or by a community health agency, unless:
- 1) the individual is eligible for services under Medicare; or
  - 2) the individual is under the age of 21, services are provided in accordance with initial treatment guidelines outlined in the provider manual; or

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- ~~3) the individual has been hospitalized within the past 30 days and was, while hospitalized, receiving therapy services; or~~
- ~~4) therapy services are being provided as a result of a Healthy Kids diagnosis and referral (89 Ill. Adm. Code 140.485).~~

- b) Approval will be granted when, in the ~~judgment~~**judgement** of a consulting physician and/or professional staff of the Department, the services are medically necessary and appropriate to meet the individual's medical needs.
- c) The decision to approve or deny a request for prior approval will be made within 21 days ~~after~~**of** the date the request and all necessary information is received.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.469 Hospice**

- a) Hospice is a continuum of palliative and supportive care, directed and coordinated by a team of professionals and volunteer workers who provide care to terminally ill persons to:
  - 1) reduce or abate pain or other symptoms of mental or physical distress;~~;~~  
and
  - 2) meet the special needs arising out of the stresses of terminal illness, dying or bereavement.
- b) Hospice care is a covered service for all eligible clients, including residents of intermediate and skilled care facilities, when provided by a Medicare certified hospice provider and in accordance with provisions contained in section 1902(a)(13)(B) of the Social Security Act (42 USC 1396a(a)(13)(B)).
- c) Covered services include:
  - 1) Nursing care;~~;~~
  - 2) Physician services;~~;~~
  - 3) Medical social services;~~;~~

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- 4) Short term inpatient care;<sup>2,5</sup>
  - 5) Medical appliances, supplies and drugs;<sup>2,5</sup>
  - 6) Home health aide services;<sup>2,5</sup>
  - 7) Occupational, physical and speech-language therapy services to control symptoms;<sup>2,5</sup> and
  - 8) Counseling services.
- d) Reimbursement shall be at the established Medicare rate for the specific level of care into which each day of care is classified. The four levels of care are:
- 1) Routine Home Care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.
  - 2) Continuous Home Care. The continuous home care rate will be paid when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.
  - 3) Inpatient Respite Care. The inpatient rate will be paid each day on which the beneficiary is in the approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth day and any subsequent days is to be made at the routine home care rate.
  - 4) General Inpatient Care. The inpatient rate will be paid when general inpatient care is provided. None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives hospice inpatient care except for the day of discharge from an

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inpatient unit. In which case, the appropriate home care rate is to be paid unless the patient dies as an inpatient.

- e) When the individual resides in an ICF or SNF facility, the Department shall provide payment of an add-on amount to the hospice on routine home care and continuous home care days. The add-on amount will constitute a portion of the facility rate the State would be responsible for as mandated by 42 CFR 418.1 through 418.205. The add-on amount for county-owned/operated nursing facilities shall be based on the rates established pursuant to Section 140.530(c)(1).
- f) The hospice shall receive an add-on amount for other physician services such as direct patient care when physician services are provided by an employee of the hospice or under arrangements made by the hospice unless those services are performed on a volunteer basis. These add-on amounts will be utilized when determining the hospice cap amount.
- g) Medicaid payment to a hospice provider for care furnished over the period of a year shall be limited by a payment cap as set forth in 42 CFR 418.309. Any overpayment shall be refunded by the hospice provider.
- h) Effective with dates of service on and after July 1, 2012, the following services will not be covered outside of the hospice program benefit for patients 21 years of age and older electing hospice care. The following services will not be paid separately:
  - 1) Dental services;
  - 2) Optometric services and eyewear;
  - 3) Nursing services provided by registered nurses and licensed practical nurses;
  - 4) Physical therapy services;
  - 5) Occupational therapy services;
  - 6) Speech therapy services;
  - 7) Audiology services;

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- 8) General clinic services;
- 9) Psychiatric clinic Type A services;
- 10) Psychiatric clinic Type B services;
- 11) Hospital outpatient physical rehabilitation;
- 12) Healthy Kids services;
- 13) Mental health rehabilitation option;
- 14) Alcohol and substance abuse rehabilitation services;
- 15) Medical equipment;
- 16) Medical supplies;
- 17) Social work services;
- 18) Psychological services;
- 19) Home health services;
- 20) Homemaker services; and
- 21) Palliative drugs.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.470 Eligible Home Health Care, Nursing and Public Health Providers**

Effective July 1, 2012:~~The Department will reimburse the following as home health care providers:~~

- a) The following classes of providers may enroll with the Department as home health care providers:

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- 1) A Medicare-certified home health agency licensed by the Department of Public Health;
- 2) A home nursing agency licensed by the Department of Public Health;
- ~~b) A home health agency certified by the Department of Public Health as Medicare certifiable or as meeting the requirements of Medicare;~~
- 3e) A self-employed nurse ~~who is~~ licensed by the Department of Financial and Professional Regulation as a registered nurse as defined by the Nurse-Nursing and Advanced Practice Nursing Act [225 ILCS 65], when there is no home health agency in the area available to provide needed services; or
- 4d) A health department certified by the Department of Public Health.;
- b) Home health care providers must implement an auditable electronic service verification.
- e) ~~A community health agency; or~~
- f) ~~A nursing agency approved by the University of Illinois at Chicago, Division of Specialized Care for Children to provide services for children and adolescents under 21 years of age.~~

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.471 Description of Home Health Care Services**

- a) Home health services are services provided for participants in their places of residence and are aimed at facilitating the transition from a more acute level of care to the home.
- b) Services provided shall be of a curative or rehabilitative nature and demonstrate progress toward goals outlined in a plan of care. Services shall be provided for individuals upon direct order of a physician and in accordance with a plan of care established by the physician and reviewed at least every 60 days.

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- c) For purposes of this Section, "residence" does not include a hospital, a skilled nursing facility, an intermediate care facility, a specialized mental health rehabilitation facility or a supportive living facility. The term "residence" includes an intermediate care facility for the mentally retarded only to the extent that home health services are not required to be provided under 89 Ill. Adm. Code 144.
- d) Effective July 1, 2012, to be eligible for reimbursement by the Department, initial certification of intermittent skilled nursing services or therapy services must have documentation that a face-to-face encounter was conducted by the practitioner requesting services. The following conditions must be met for the face-to-face encounter:
- 1) The physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start of care date or within 30 days after the start of the home health care by including the date of the encounter and including an explanation of why the clinical findings of the encounter support that the patient is in need of either intermittent skilled nursing services or therapy services as defined in Section 140.472.
  - 2) The face-to-face encounter must be performed by the certifying physician, a nurse practitioner, a clinical nurse specialist who is working in collaboration with the physician in accordance with State law, a certified nurse midwife as authorized by State law, a physician assistant under the supervision of the physician, or, for patients admitted to home health immediately after an acute or post-acute stay, the physician who cared for the patient in an acute or post-acute facility and who has privileges at the facility. The documentation of the face-to-face encounter must be a separate and distinct section of, or an addendum to, the certification and must be clearly titled, dated and signed by the certifying physician.
    - A) If the certifying physician does not perform the face-to-face encounter personally, the nonphysician practitioner or the physician who cared for the patient in an acute or post-acute facility performing the face-to-face encounter must communicate the clinical findings of that face-to-face patient encounter to the certifying physician.

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- B) If a face-to-face patient encounter occurred within 90 days prior to the start of care but is not related to the primary reason the patient requires home health services, or the patient has not seen the certifying physician or allowed nonphysician practitioner within the 90 days prior to the start of the home health episode, the certifying physician or nonphysician practitioner must have a face-to-face encounter with the patient within 30 days after the start of the home health care.
- C) The face-to-face patient encounter may occur through telehealth, in compliance with Section 140.403.
- D) The physician responsible for certifying the patient for home care must document the face-to-face encounter on the certification itself, or as an addendum to the certification (as described in subsection (d)(1)) that the condition for which the patient was being treated in the face-to-face patient encounter is related to the primary reason the patient requires home health services, and why the clinical findings of the encounter support that the patient is in need of either intermittent skilled nursing services or therapy services as defined in Section 140.472. The documentation must be clearly titled, dated and signed by the certifying physician.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.472 Types of Home Health Care Services**

The types of services for which payment can be made are:

- a) Intermittent skilled nursing in the home for the purpose of completing an assessment, evaluation or administration.
- b) Shift nursing care in the home for the purpose of caring for a participant under 21 years of age who has extensive medical needs and requires ongoing skilled nursing care.
- c) Home health aide.~~Health Aid.~~

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- d) ~~Speech~~ Therapy services: Effective July 1, 2012, speech, occupational and physical therapy services are limited to a maximum of 20 visits per State fiscal year for participants who are age 21 and over. These services require prior approval by the Department.
- e) ~~Occupational Therapy.~~
- f) ~~Physical Therapy.~~

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.473 Prior Approval for Home Health Care Services**

- a) Prior approval is required for the provision of home health services described in Section 140.472. The decision to approve or deny a request for prior approval will be made within 21 days after the date the request is received or within 21 days after receipt of additional information, whichever occurs later. Prior approval is also required for participants needing more than one skilled nursing visit per day.
- b) Prior approval is required for the provision of all home health services to terminally ill participants covered under the Transitional Assistance Program and the Family and Children Assistance Program.
- c) Effective July 1, 2012, prior ~~Prior~~ approval is not required for intermittent skilled nursing services provided by a home health agency provider for participants within the first 60 days after discharge of service provided by a home health agency provider for participants discharged from an acute care or rehabilitation hospital when services are initiated within 14 days after discharge.
- d) Prior approval is required for all in-home shift nursing for children who are under 21 years of age. The decision to approve or deny a request for prior approval will be made within 21 days after the date the request is received or within 21 days after receipt of additional information, whichever occurs later. Review of services for children eligible for in-home shift nursing under the Illinois Home and Community-Based Services Waiver for Medically Fragile, Technology Dependent Children will be made in accordance with 89 Ill. Adm. Code 120.530.
- e) Approval will be granted when, in the judgment of a consulting physician and

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subject to the review of the professional staff of the Department, the services are medically necessary and appropriate to meet the participant's medical needs.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.474 Payment for Home Health Care Services**

- a) Effective July 1, 2012, except ~~Except~~ for services described in subsections (b) and (c) of this Section, home health agencies shall be paid an all inclusive, per visit rate which shall be the lowest of the:
- 1) Agency's ~~the agency's~~ usual and customary charge for the service;
  - 2) Agency's ~~the agency's~~ Medicare rate; or
  - 3) ~~the~~ Department's maximum allowable rate of as identified in the Home Health Fee Schedule (see the Department's website) \$65.25. Beginning with the State fiscal year 2002, the maximum allowable rate may be adjusted annually in consideration of the appropriation of funds by the General Assembly.
- b) Payment to self-employed registered nurses providing in-home nursing services is made at the community rate for those such ~~such~~ services as determined for each case at the time prior approval is given.
- c) Payment for in-home shift nursing for children who are under 21 years of age under Section 140.472(b) shall be at the Department's established hourly rate to an agency licensed to provide these services. The hourly rate for in-home shift nursing care may be adjusted in consideration of the appropriation of funds by the General Assembly.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices**

- a) Effective July 1, 2012, prior ~~Prior~~ approval for the purchase, repair or rental of certain medical equipment, prosthetic devices and orthotic devices is required except when:

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- 1) The client is a Medicare beneficiary and the item requested has been reimbursed under the Medicare program; or
  - 2) ~~Repair costs do not exceed 75 percent of the purchase price and the item is not covered by a warranty; or~~
  - 23) The item is being loaned pending repair or replacement of the recipient's own item.
- b) Replacement of covered equipment, prosthetic devices and orthotic devices is subject to all policies that apply to an original purchase of the same item. Replacements will not be reimbursed by the Department if the original item is under a warranty that would cover the necessary repairs or replacement. If the item requires prior approval and if the item was purchased by the Department for the same client within the past 12 months, the Department's original determination of medical necessity will be deemed adequate for the replacement purchase. In this case, the request for prior approval must contain an explanation of the need for replacement. The Department may deny payment for replacement of equipment if evidence indicates that breakage or loss has resulted from abuse of the equipment.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.498 Fingerprint-Based Criminal Background Checks**

- a) ~~Non-Emergency Transportation~~
- a)→ Vendors who pose a risk of fraud, waste, abuse or harm~~Non-emergency transportation vendors~~, as defined in Section 140.13, and applicants of the Medical Assistance Program shall submit to a fingerprint-based criminal background check on current and future information available in the State system for criminal background checks, and current information available through the Federal Bureau of Investigation's fingerprint system, by submitting all necessary fees and information in the form and manner prescribed by the Illinois State Police. New vendor applicants must submit to fingerprint-based criminal background checks within 30 days after the submission of the application. ~~When~~At such times as the Department ~~initiates~~may initiate a re-enrollment of all ~~classes of non-emergency transportation~~ vendors pursuant to Section 140.11(e), the Department may require ~~the~~such vendors to re-submit to fingerprint-based

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criminal background checks as provided in this Section. Fingerprint-based criminal background checks requested pursuant to Section 140.11(e) must be submitted within 60 days after the submission of ~~thesuch~~ updated enrollment information. Vendors shall be responsible for the payment of the costs of fingerprint-based criminal background checks.

- ~~b)2)~~ The following individuals shall be subject to the fingerprint-based background check:
- ~~1)A)~~ In the case of a vendor that is a corporation, all officers and individuals owning, directly or indirectly, five percent or more of the shares of stock or other evidence of ownership in a corporate vendor.
  - ~~2)B)~~ In the case of a vendor that is a partnership, every partner.
  - ~~3)C)~~ In the case of a vendor that is a sole proprietorship, the sole proprietor.
  - ~~4)D)~~ Each officer and each individual with management responsibility of the vendor.
- ~~c)3)~~ All individuals required to submit to a fingerprint-based criminal background check must submit their fingerprints to a fingerprint vendor approved by the Illinois State Police. The Department shall provide a list of all approved fingerprint vendors.
- ~~d)4)~~ Within 30 days after any individual identified in subsection ~~(b)(a)(2) of this Section~~ acquiring an ownership interest, pursuant to subsection ~~(b)(1), (b)(2) or (b)(3)(a)(2)(A), (B) or (C) of this Section~~, or assuming management responsibility, pursuant to subsection ~~(b)(4)(a)(2)(D) of this Section~~, the vendor must notify the Department of ~~thesuch~~ change and the individual must submit to a fingerprint-based criminal background check within 30 days after ~~such~~ notification.
- ~~e)5)~~ The failure of any individual identified in ~~subsection (b) subsections (a)(2)(A), (B), (C) and (D) of this Section~~ to submit to a fingerprint-based criminal background check, as provided for in this Section, or to provide notification as required in subsection ~~(d)(a)(4) of this Section~~, will result in the denial of an application or re-application (pursuant to Section 140.11(e)) to participate in the Medical Assistance Program or may result in ~~disenrollment~~~~dis-enrollment~~, termination or suspension of an enrolled vendor.

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~~1)C)~~ This Section does not apply to:

~~1)A)~~ Vendors owned or operated by government agencies; and

~~2)B)~~ Private automobiles.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

**Section 140.523 Bed Reserves**

a) ~~Effective for dates of service on or after July 1, 2012, no payments for bed reserve days will be made to a facility licensed under the Nursing Home Care Act [210 ILCS 45] or the Specialized Mental Rehabilitation Act [210 ILCS 48].~~  
Nursing Facilities

~~1) All payable bed reserves must:~~

~~A) be authorized by a physician;~~

~~B) have post payment approval from Bureau of Long Term Care staff based on satisfying the requirements of this Section;~~

~~C) be limited to residents who desire to return to the same facility; and~~

~~D) be limited to facilities having a 93 percent or higher occupancy level and, of that occupancy level, 90 percent or higher shall be Medicaid eligible. The occupancy level shall be calculated including both payable and non-payable (non-payable defined as those residents that have transitioned from the maximum days allowed for payable bed reserve to non-payable bed reserve status) bed reserve days as occupied beds.~~

~~2) The Department shall make payment for resident absences due to hospitalization. In such instances, bed reserve is limited to ten days per hospital stay. In accordance with the Nursing Home Care Act [210 ILCS 45/3-401.1], a recipient or applicant shall be considered a resident in the nursing facility during any hospital stay totaling ten days or less following~~

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~~a hospital admission. The day the resident is transferred to the hospital is the first day of the reserve bed period.~~

- ~~3) Payment may be approved for home visits which have been indicated by a physician as therapeutically beneficial. In such instances, bed reserve is limited to seven consecutive days in a billing month or ten non-consecutive days in a billing month. The day after the resident leaves the facility for a therapeutic home visit is the first day of the payable or nonpayable reserve bed period. Home visits may be extended with the approval of the Department.~~
- ~~4) Bureau of Long Term Care staff will approve ongoing therapeutic home visits based on the physician's standing orders for the individual. Standing orders for therapeutic home visits limited to ten days per month are valid for a period not exceeding six months.~~
- ~~5) Payment for approved bed reserves is a daily rate at 75 percent of an individual's current Medicaid per diem.~~
- ~~6) In no facility may the number of vacant beds be less than the number of beds identified for residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.~~

b) Effective July 1, 2012, ICF/MR Facilities (including ICF/DD and SNF/Ped licenses)

- 1) All bed reserves must:
  - A) be authorized by the interdisciplinary team (IDT); ~~and~~
  - B) be limited to residents who desire to return to the same facility; and-
  - C) be for persons who are under 21 years of age.
- 2) There is no minimum occupancy level ICF/MR facilities must meet for receiving bed reserve payments.

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- 3) In no facility may the number of vacant beds be less than the number of beds identified for residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.
- 4) Payment may be approved for hospitalization for a period not to exceed 45 consecutive days. The day the resident is transferred to the hospital is the first day of the reserve bed period. Payment for approved bed reserves for hospitalization is a daily rate at:
  - A) ~~100% percent~~ of a facility's current Medicaid per diem for the first ~~10 ten~~ days of an admission to a hospital;
  - B) ~~75% percent~~ of a facility's current Medicaid per diem for days 11 through 30 of the admission;
  - C) ~~50% percent~~ of a facility's current Medicaid per diem for days 31 to 45 of the admission.
- 5) Payment may be approved for therapeutic visits which have been indicated by the IDT as therapeutically beneficial. There is no limitation on the bed reserve days for such approved therapeutic visits. The day after the resident leaves the facility is the first day of the bed reserve period. Payment for approved bed reserves for therapeutic visits is a daily rate at:
  - A) ~~100% percent~~ of a facility's current Medicaid per diem for a period not to exceed ~~10 ten~~ days per State fiscal year;
  - B) ~~75% percent~~ of a facility's current Medicaid per diem for a period which exceeds ~~10 ten~~ days per State fiscal year.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

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**Section 140. TABLE D Schedule of Dental Procedures**

Effective July 1, 2012:

- a) Diagnostic Services
  - 1) Clinical Oral Examinations
    - A) Periodic oral evaluation, ages 0-20 years, once every 12 months
    - B) Limited oral examination – problem focused in conjunction with an emergency visit
    - C) Comprehensive oral examination, once per patient, per lifetime, per dentist or group
  - 2) Clinical oral examinations for adults age 21 and older are limited oral examination-problem focused in conjunction with an emergency visit.
  - 3)2) Radiographs
    - A) Intraoral, complete series (including bitewings), once per 36 months, complete series every 36 months
    - B) Intraoral – periapical – first film, maximum of one per day, per provider or group
    - C) Intraoral – periapical – additional film, maximum of five per day
    - D) Bitewing – single film
    - E) Bitewings – two films
    - F) Bitewings – four films
    - G) Vertical bitewings – 7-8 films
    - H) Panoramic film, one per 36 months

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- b) Preventive Services
  - 1) Prophylaxis, ages 2-20 years, once every 6 months
  - 2) Topical application of fluoride, ages 2-20 years, once every 12 months
  - 3) Sealant – per tooth, ages 5-17 years, occlusal surfaces of the permanent first and second molars, once per lifetime
  - 4) Space maintainer – fixed unilateral, ages 2-20 years
  - 5) Space maintainer – fixed bilateral, ages 2-20 years
  - 6) Space maintainer – removable bilateral type, ages 2-20 years
  - 7) Recementation of space maintainer, ages 2-20 years
- c) Restorative Services
  - 1) Amalgam Restorations
    - A) Amalgam – 1 surface, primary
    - B) Amalgam – 2 surfaces, primary
    - C) Amalgam – 3 surfaces, primary
    - D) Amalgam – 4 plus surfaces, primary
    - E) Amalgam – 1 surface, permanent
    - F) Amalgam – 2 surfaces, permanent
    - G) Amalgam – 3 surfaces, permanent
    - H) Amalgam – 4 plus surfaces, permanent
  - 2) Composite Restorations
    - A) Resin-based composite – 1 surface, anterior

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- B) Resin-based composite – 2 surfaces, anterior
  - C) Resin-based composite – 3 surfaces, anterior
  - D) Resin-based composite – 4 or more surfaces, or including the incisal edge
  - E) Resin-based composite – 1 surface, posterior, primary
  - F) Resin-based composite – 2 surfaces, posterior, primary
  - G) Resin-based composite – 3 or more surfaces, posterior, primary
  - H) Resin-based composite – 1 surface, posterior, permanent
  - I) Resin-based composite – 2 surfaces, posterior, permanent
  - J) Resin-based composite – 3 surfaces, posterior, permanent
  - K) Resin-based composite – 4 or more surfaces, posterior, permanent
- 3) Other Restorative
- A) Crown – porcelain/base metal
  - B) Crown – full cast base metal
  - C) Prefabricated stainless steel crown, primary tooth, ages 2-20 years
  - D) Prefabricated stainless steel crown, permanent tooth, ages 2 years and over
  - E) Prefabricated resin crown, ages 2 years and over
  - F) Sedative fillings
  - G) Pin retention – per tooth

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- H) Prefabricated post and core
  - I) Recement inlays
  - J) Recement crown
- d) Endodontic Services
- 1) Therapeutic pulpotomy, primary teeth only, ages 2-20 years
  - 2) Root canal therapy (including exam, clinical procedure, necessary radiographs and follow up)
    - A) Anterior root canal (excluding final restoration), ages 2 years and over
    - B) Bicuspid root canal (excluding final restoration), ages 2-20 years
    - C) Molar root canal (excluding final restoration), ages 2-20 years
    - D) Apexification/recalcification, initial visit, ages 2-20 years
    - E) Apexification/recalcification, interim visit, ages 2-20 years
    - F) Apexification/recalcification, final visit, ages 2-20 years
    - G) Apicoectomy/periradicular surgery – per tooth, first root, ages 2-20 years
- e) Periodontic Services/Periodontal Treatment
- 1) Gingivectomy or gingivoplasty – per quadrant, ages 0-20 years
  - 2) Gingivectomy or gingivoplasty – per tooth, ages 0-20 years
  - 3) Gingival flap procedure, including root planing – per quadrant, ages 0-20 years
  - 4) Osseous surgery – per quadrant, ages 0-20 years

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- 5) Bone replacement graft – first site in quadrant, ages 0-20 years
  - 6) Bone replacement graft – each additional site in quadrant, ages 0-20 years
  - 7) Pedicle soft tissue graft, ages 0-20 years
  - 8) Free soft tissue graft, ages 0-20 years
  - 9) Subepithelial connective tissue graft procedure, ages 0-20 years
  - 10) Distal or proximal wedge procedure, ages 0-20 years
  - 11) Provisional splinting, intracoronal, ages 0-20 years
  - 12) Provisional splinting, extracoronal, ages 0-20 years
  - 13) Periodontal scaling and root planing – per quadrant, ages 0-20 years
  - 14) Periodontal maintenance procedure, ages 0-20 years
- f) Removable Prosthodontic Services (every five years based on age of prior placement)
- 1) Complete Dentures – including six months' post delivery care
    - A) Complete denture – maxillary
    - B) Complete denture – mandibular
    - C) Immediate denture – maxillary
    - D) Immediate denture – mandibular
  - 2) Partial Dentures – including six months' post delivery care
    - A) Maxillary partial denture – resin base, ages 2-20 years
    - B) Mandibular partial denture – resin base, ages 2-20 years

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- C) Maxillary partial denture – cast metal framework, ages 2-20 years
  - D) Mandibular partial denture – cast metal framework, ages 2-20 years
- 3) Repairs to Dentures
- A) Repair complete denture
  - B) Replace missing or broken teeth, complete denture (each tooth)
  - C) Repair partial denture base
  - D) Repair cast framework
  - E) Repair or replace broken clasp
  - F) Replace broken teeth, per tooth
  - G) Add tooth to existing partial
- 4) Denture Reline Procedures (covered once every 24 months)
- A) Reline complete maxillary denture, chairside
  - B) Reline complete mandibular denture, chairside
  - C) Reline maxillary partial denture, chairside
  - D) Reline mandibular partial denture, chairside
  - E) Reline complete maxillary denture, laboratory
  - F) Reline complete mandibular denture, laboratory
  - G) Reline maxillary partial denture, laboratory
  - H) Reline mandibular partial denture, laboratory

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- 5) Maxillofacial Prosthetics
  - A) Facial moulage – sectional
  - B) Facial moulage – complete
  - C) Nasal prosthesis
  - D) Auricular prosthesis
  - E) Orbital prosthesis
  - F) Ocular prosthesis
  - G) Facial prosthesis
  - H) Nasal septal prosthesis
  - I) Ocular prosthesis, interim
  - J) Cranial prosthesis
  - K) Facial augmentation implant prosthesis
  - L) Nasal prosthesis, replacement
  - M) Auricular prosthesis, replacement
  - N) Orbital prosthesis, replacement
  - O) Facial prosthesis, replacement
  - P) Obturator prosthesis, surgical
  - Q) Obturator prosthesis, definitive
  - R) Obturator prosthesis, modification
  - S) Mandibular resection, prosthesis with guide flange

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- T) Mandibular resection, prosthesis without guide flanges
  - U) Obturator prosthesis, interim
  - V) Trismus appliance
  - W) Feeding aid
  - X) Speech aid prosthesis
  - Y) Palatal augmentation prosthesis
  - Z) Palatal lift prosthesis, definitive
  - AA) Palatal lift prosthesis, interim
  - BB) Palatal lift prosthesis, modification
  - CC) Speech aid prosthesis, modification
  - DD) Surgical stent
  - EE) Radiation carrier
  - FF) Radiation shield
  - GG) Radiation cone locator
  - HH) Fluoride gel carrier
  - II) Commissure splint
  - JJ) Surgical splint
  - KK) Unspecified maxillofacial prosthesis
- g) Fixed Prosthetic Services
- 1) Bridge Pontics

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- A) Pontic – porcelain fused to predominantly base metal, ages 2-20 years
- B) Pontic – resin with predominantly base metal, ages 2-20 years
- 2) Bridge Retainer Crowns
  - A) Crown – resin with predominantly base metal, ages 2-20 years
  - B) Crown – porcelain with predominantly base metal, ages 2-20 years
- 3) Other Prosthetic Services
  - A) Recement fixed partial denture
  - B) Prefabricated post and core in addition to fixed partial denture retainer, ages 2-20 years
- h) Oral and Maxillofacial Services
  - 1) Simple Extractions
    - A) Single tooth extraction
    - B) Each additional extraction
    - C) Root removal, exposed roots
  - 2) Simple Extractions for Adults Age 21 and Older  
Single tooth extraction
  - ~~3)2)~~ Surgical Extractions
    - A) Surgical removal of erupted tooth
    - B) Removal of impacted tooth – soft tissues
    - C) Removal of impacted tooth – partially bony

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D) Removal of impacted tooth – completely bony

E) Surgical removal of residual roots

4) Surgical Extractions for Adults Age 21 and Older  
Surgical removal of residual roots

5)3) Other Surgical Procedures  
Surgical exposure to aid eruption, ages 2-20 years

6)4) Alveoloplasty

A) Alveoloplasty in conjunction with extractions, ages 2-20 years

B) Alveoloplasty not in conjunction with extractions, ages 2-20 years

7)5) Removal of Cysts and Neoplasms

A) Removal of odontogenic cyst or tumor, up to 1.25 cm

B) Removal of odontogenic cyst or tumor, over 1.25 cm

C) Removal of non-odontogenic cyst or tumor, up to 1.25 cm

D) Removal of non-odontogenic cyst or tumor, over 1.25 cm

E) Incision and drainage of abscess

8)6) Treatment of Fractures – Simple

A) Maxilla – open reduction, teeth immobilized

B) Maxilla – closed reduction, teeth immobilized

C) Mandible – open reduction, teeth immobilized

D) Mandible – closed reduction, teeth immobilized

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~~9)7~~ Treatment of Fractures – Compound

- A) Maxilla – open reduction
- B) Maxilla – closed reduction
- C) Mandible – open reduction
- D) Mandible – closed reduction

~~10)8~~ Reduction of Dislocation

- A) Open reduction of dislocation
- B) Closed reduction of dislocation

~~11)9~~ Other Oral Surgery

Frenulectomy – separate procedure (frenectomy or frenotomy), ages 2-20 years

- i) Orthodontic Services – for ages 2-20 years
  - 1) Initial examination, records, study models, radiographs, and facial photographs, ages 2-20 years
  - 2) Initial orthodontic appliance placement, ages 2-20 years
  - 3) Monthly adjustments, ages 2-20 years
  - 4) Initial orthodontic evaluation/study models, ages 2-20 years (for cases that fail to reach 42 points on the Modified Salzman Index).
- j) Adjunctive General Services
  - 1) Unclassified Treatment
    - A) Palliative (emergency) treatment of dental pain – minor procedures
    - B) General anesthesia

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- C) Analgesia, anxiolysis, inhalation of nitrous oxide
- D) Intravenous sedation
- 2) Unclassified Treatment for Adults Age 21 and Older
  - A) Analgesia, anxiolysis, inhalation of nitrous oxide
  - B) Non-Intravenous Conscious Sedation
- 3)2) Professional Consultation  
Consultation (narrative; diagnostic services provided by dentist other than practitioner providing treatment)
- 4)3) Drugs
  - A) Therapeutic drug injection
  - B) Other drugs and medicaments
- 5)4) Miscellaneous Services
  - A) Unspecified ~~procedures~~procedure by report to be described by statement of attending dentist
  - B) Dental procedures otherwise not covered for adults age 21 and older when determined by the Department to be a necessary prerequisite for required medical care.

(Source: Amended at 37 Ill. Reg. 10282, effective June 27, 2013)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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**Section 140. TABLE F Podiatry Service Schedule (Repealed)**

- a) ~~Podiatric Medical Visits~~
  - 1) ~~Office Visits~~
    - A) ~~Visit office—(new patient) evaluation, history, examination, with treatment~~
    - B) ~~Visit office—(established patient) examination, evaluation and/or treatment, same or new illness~~
  - 2) ~~Home Visits~~
    - A) ~~Visit home~~
    - B) ~~Evaluation, history, examination and treatment~~
  - 3) ~~Hospital Visits~~
    - A) ~~Visit hospital—(new or established patient) history and physical examination, including treatment~~
    - B) ~~Extended Care Facilities, Convalescent Hospital Nursing Home, and Boarding Home Visits~~
    - C) ~~Visit facility—(first patient seen) history and physical examination, including care or treatment~~
    - D) ~~Visit facility—(coinciding visit) history and physical examination, including treatment of additional patient (e.g., a patient that is seen concurrently with other patient(s) during the doctor's visit at the facility).~~
  - 4) ~~Consultations~~
    - ~~\*Consultation of unusual complexity requiring review of prior medical records, the compilation and assessment of data and preparation of special report, at home, office or hospital~~

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- b) ~~Podiatric Diagnostic Radiology—Definitions~~
- 1) ~~Foot, single, limited, two views—1 plate~~
  - 2) ~~Feet, both limited, two views—2 plates~~
  - 3) ~~Foot and ankle, complete, minimum of three views—3 plates~~
- e) ~~Podiatric Pathology~~
- 1) ~~Urinalysis~~
  - 2) ~~Urinalysis, routine, complete~~
  - 3) ~~Chemistry~~
  - 4) ~~Sugar (glucose), blood~~
  - 5) ~~Uric acid, blood, chemical~~
  - 6) ~~Hematology~~
  - 7) ~~Bleeding time~~
  - 8) ~~Blood count, complete (includes rbc, wbc, hgb, differential)~~
  - 9) ~~Coagulation time (Lee and White)~~
  - 10) ~~Sedimentation rate (esr)~~
  - 11) ~~Immunology~~
  - 12) ~~Latex fixation, rheumatoid factor~~
  - 13) ~~Microbiology~~
  - 14) ~~Microbial analysis, microscopic examination, stain for bacteria, fungi, parasites, inclusion bodies, etc.~~

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- 15) ~~Microbial analysis, fungi, microscopic and macroscopic (culture)~~
- d) ~~Physical Medicine~~  
~~Any of the accepted physical therapy modalities when used in combination with an office visit.~~
- e) ~~Surgical Procedures~~
- 1) ~~Integumentary System~~
- A) ~~Incision~~
- B) ~~Incision and drainage of subcutaneous abscess~~
- C) ~~Incision and drainage of onychia or paronychia with partial or total excision or avulsion of nail and with or without excision of granulation tissue~~
- D) ~~Incision and removal of foreign body, subungual or subcutaneous issues~~
- E) ~~Benign Lesions~~
- F) ~~\*\*Excision of small neoplastic, cicatricial, inflammatory or congenital lesion of skin or subcutaneous tissue (e.g. verrucae, plantar keratosis, fibroma, etc.)~~
- G) ~~Nails~~
- H) ~~\*\*Avulsion or excision of nail plate, partial or complete, simple~~
- I) ~~Excision of nail, nail bed, and/or nail fold with excision of matrix and plasty (onychectomy with plasty or onychoplasty), partial~~
- J) ~~Onychoplasty (onychectomy with plasty) total~~
- K) ~~Excision, complete (total) of nail bed and/or nail fold, with excision of matrix and with partial ostectomy of distal phalanx and plasty of toe (onychectomy with dactyloplasty or terminal Symes)~~

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- L) ~~Destruction of nail root and matrix with partial excision of avulsion of nail using one of the following methods: Negative galvanism, electrocoagulation, fulguration or dessication, phenolization, cryocautery (CO<sub>2</sub>, N<sub>2</sub>), or with power surgical drill or burr~~
- M) ~~Same as above—total nail~~
- N) ~~Introduction~~
- O) ~~Injection of a corticosteroid solution to lesion(s)~~
- P) ~~Repair—Simple~~
- Q) ~~\*Wound, repair of, (e.g., suture of, etc.)~~
- R) ~~Destruction~~
- S) ~~\*\*Electrosurgical destruction, with or without surgical currettement of small, single lesion, (e.g., verruca, nevus, keratosis, etc.)~~
- 2) Specific
  - A) ~~Incision~~
  - B) ~~Tenotomy, subcutaneous, corrective~~
  - C) ~~Tenoplasty for lengthening or shortening of tendon of toe, unilateral, (independent procedure)~~
  - D) ~~Excision~~
  - E) ~~Excision of peripheral neuroma (Morton's neuroma, neurofibroma, Schwannoma, etc.) of digit or interdigital regions of lesser toes, single~~
  - F) ~~Excision of lesion of tendon or fibrous sheath or capsule (e.g., cyst~~

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~~or ganglion, etc.) from the foot~~

- ~~G) Excision of chondroma, exostosis, osteochondroma, osteoma, etc., from a tarsal bone, other than the calcaneus or talus, by open reduction.~~
- ~~H) Same as item above— from the calcaneus, by open reduction~~
- ~~I) Same as item above— from a calcaneus, by subcutaneous (percutaneous) technique using rasp or drill~~
- ~~J) Same as item above— from a phalangeal bone, subcutaneous method~~
- ~~K) Osteotomy, partial excision of fifth metatarsal head (e.g., bunionette, independent procedure)~~
- ~~L) Osteotomy, partial excision of metatarsal head (e.g., metatarsectomy, partial, such as a condylectomy or excision of head of metatarsal)~~
- ~~M) Osteotomy, partial excision of a phalanx (phalangeectomy, partial such as condylectomy or excision of head or phalanx)~~
- ~~N) Osteotomy, partial, of calcaneus for Haglund's deformity~~
- ~~O) Phalangeectomy, lesser toe, total~~
- ~~P) Sesamoidectomy (independent procedure and not part of a procedure for the repair of a hallux valgus)~~
- ~~Q) Capsulotomy, open, for contracture, metatarsophalangeal joint, with or without tenorrhaphy (independent procedure)~~
- ~~R) Same as item above— subcutaneous ("percutaneous") procedure (e.g., capsulotomy, with or without tentomy of a metatarsophalangeal joint)~~
- ~~S) Hallux valgus, correction by exostectomy (e.g., Silver Type~~

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- ~~procedure or any modification thereof, etc.) unilateral~~
- T) ~~Same as item above—McBride or any modification thereof~~
- U) ~~Arthroplasty, metatarsophalangeal joint of great toe, (e.g., hallux valgus repair by Keller, Mayo, or Stone, etc., procedures with or without use of implant)~~
- V) ~~Osteotomy (e.g., cutting, division or transection of bone, with or without fixation. Independent procedure and/or part of a repair procedure for hallux valgus) for shortening or angular correction, (e.g., dorsal wedge osteotomy with internal fixation, base wedge osteotomy, extension osteoarthrotomy, etc.) of first metatarsal bone~~
- W) ~~Same as item above—for a lesser metatarsal bone, single, unilateral~~
- X) ~~Subcutaneous ("percutaneous") metaphyseal osteotomy (osteoclasis), first metatarsal, for shortening, angular, or rotational correction~~
- Y) ~~Same as item above—for a lesser metatarsal, single (percutaneous)~~
- Z) ~~Fracture and/or dislocation~~
- AA) ~~\*Tibia or Fibula, ankle, closed (simple), without reduction~~
- BB) ~~\*OS Calcis, fracture, closed (simple), without reduction~~
- CC) ~~\*Astragalus talus, fracture, closed (simple), without reduction~~
- DD) ~~\*Tarsal bone(s) (except astragalus or os calcis), fracture(s), closed (simple), without reduction~~
- EE) ~~\*Metatarsal fracture, first metatarsal bone, closed (simple), without reduction~~

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- ~~FF) Metatarsal(s) (other than first metatarsal bone) fracture(s), closed (simple), without reduction~~
  - ~~GG) \*Phalanx or phalanges, fracture great toe, closed (simple), without reduction~~
  - ~~HH) \*Same as item above—other than great toe, without reduction~~
  - ~~II) Metatarsal—phalangeal joint, dislocation, closed (simple), manipulative reduction requiring anesthesia~~
  - ~~JJ) Interphalangeal joint, dislocation, closed (simple), manipulative reduction, requiring anesthesia~~
  - ~~KK) Strapping~~
  - ~~LL) Unna Boot~~
- f) Orthomechanical Procedures
- 1) Metal Foot Plates
  - 2) Shaeffer plate (custom made to model), pair
  - 3) Roberts Foot plate (custom made to model), pair
  - 4) Whitman Foot plate or brace (custom made to model), pair
  - 5) Thermoplastic Plates, (Biomechanical)
  - 6) Stabilization and/or mobilization of foot by use of a thermoplastic orthotic (custom made to model and biomechanically), with forefoot post, pair
  - 7) Molded Inlays (Balance Inlays)
  - 8) The stabilization, balance and mobilization of the foot, partial or total by use of a full extension or partial molded inlay made to foot models with an evaluation up to  $\frac{3}{4}$ " and with a matching insert as an interior shoe modification. Removable type. (All types of balance inlays, Bergmann,

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- ~~Levy, Brachman, Contura, Molded Latex, etc.) Single with matching insert or a pair~~
- 9) Shoes
  - 10) ~~Custom made, to models, of contour or space shoes with interior modifications, pair~~
  - 11) Shoe Modifications (exterior)
  - 12) ~~Stabilization and/or mobilization of foot by use of exterior modifications to shoes, such as orthopedic heels, comma bars, heel or sole wedges, etc., pair~~
  - 13) ~~Shoe Modifications, Interior (Shoe padding, etc.)~~
  - 14) ~~The stabilizaiton and removal of pressure from the affected areas of the feet by use and application of accommodative shoe paddings to the interior of the shoes, pair~~
  - 15) ~~Insole Extra (e.g., "Spenco", "Ailplast" cork, "Celastex" Kwik Mold, Styrofoam, Leather, etc.)~~
  - 16) Splints, Mechanical
  - 17) ~~Mobilization and/or partial immobilization of joint motions in foot and leg, by use of splints attached to shoes and adjusted as indicated for the specific deformity~~
  - 18) Protective Devices
  - 19) ~~Protective devices for the alleviation or dispersion of pressure, such as from digital deformities, foot deformities, and skin lesions such as ulcers, clavi, hyperkeratoses, etc. Latex bunion~~
  - 20) Same as above but for a latex hammer toe shield, single

~~\*AGENCY NOTE: Report must accompany billing statement~~

~~\*\*AGENCY NOTE: With use of local anesthesia~~

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Source: Repealed at 37 Ill. Reg. 10282, effective June 27, 2013)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Hospital Services
- 2) Code Citation: 89 Ill. Adm. Code 148
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
148.70	Amendment
148.117	Amendment
148.126	Amendment
148.140	Amendment
148.190	Amendment
148.240	Amendment
148.285	Repeal
148.295	Amendment
148.458	Amendment
148.510	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and P.A. 97-0689
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: February 1, 2013; 37 Ill. Reg. 1018 and April 12, 2013; 37 Ill. Reg. 4455
- 10) Has JCARE issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: The following changes have been made:

In subsection (c)(2) of Section 148.126, changed "\$41" to "\$121", "\$164" to "\$244", "~~December 31, 2014~~" to "June 30, 2013", and "~~January 1, 2015~~" to "July 1, 2013".

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In subsection (c)(20) of Section 148.126, changed "\$662" to "\$1986", "~~December 31, 2014~~" to "June 30, 2013", and changed "~~January 1, 2015~~" to "July 1, 2013".

In subsection (a) of Section 148.190, changed "Effective July 1, 2013", to "Effective July 1, 2012".

In subsection (a)(1) of Section 148.190, changed "447.50 et seq., which for dates of services" to "447.50 et seq., which, for dates of service", added "in federal regulations" before "at 42 CFR 447.50 et seq.,"; deleted "which for federal fiscal year 2012 is \$3.90."; and added "which for dates of service beginning July 1, 2012 through March 31, 2013, is \$3.65. Beginning April 1, 2013, the nominal copayment amount is \$3.90."

In subsection (a)(2) of Section 148.190, added "in federal regulations" before "at 42 CFR 447.50 et seq.", deleted "which for federal fiscal year 2012 is \$3.90."; and added "which for dates of service beginning July 1, 2012 through March 31, 2013, is \$3.65. Beginning April 1, 2013, the nominal copayment amount is \$3.90."

- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? Yes, July 13, 2012; 36 Ill. Reg. 10326 and December 28, 2012; 36 Ill Reg. 18976
- 14) Are there any other rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: These administrative rules are authorized by SMART, which mandates adjustments to co-pays, reductions in payment for certain hospital services, and extension of certain supplemental payments to hospitals through December 31, 2014 to coincide with extension of the hospital assessment program.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

The full text of the Adopted Amendments begins on the next page:

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## SUBCHAPTER d: MEDICAL PROGRAMS

## PART 148

## HOSPITAL SERVICES

## SUBPART A: GENERAL PROVISIONS

## Section

148.10	Hospital Services
148.20	Participation
148.25	Definitions and Applicability
148.30	General Requirements
148.40	Special Requirements
148.50	Covered Hospital Services
148.60	Services Not Covered as Hospital Services
148.70	Limitation On Hospital Services

## SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

## Section

148.80	Organ Transplants Services Covered Under Medicaid (Repealed)
148.82	Organ Transplant Services
148.85	Supplemental Tertiary Care Adjustment Payments
148.90	Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments
148.95	Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments
148.100	Outpatient Rural Hospital Adjustment Payments
148.103	Outpatient Service Adjustment Payments
148.105	Psychiatric Adjustment Payments
148.110	Psychiatric Base Rate Adjustment Payments
148.112	High Volume Adjustment Payments
148.115	Rural Adjustment Payments
148.117	Outpatient Assistance Adjustment Payments
148.120	Disproportionate Share Hospital (DSH) Adjustments
148.122	Medicaid Percentage Adjustments
148.126	Safety Net Adjustment Payments
148.130	Outlier Adjustments for Exceptionally Costly Stays
148.140	Hospital Outpatient and Clinic Services

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- 148.150 Public Law 103-66 Requirements
- 148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million
- 148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act
- 148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act
- 148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting
- 148.190 Copayments
- 148.200 Alternate Reimbursement Systems
- 148.210 Filing Cost Reports
- 148.220 Pre September 1, 1991, Admissions
- 148.230 Admissions Occurring on or after September 1, 1991
- 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
- 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
- 148.260 Calculation and Definitions of Inpatient Per Diem Rates
- 148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals
- 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements
- 148.285 Excellence in Academic Medicine Payments (Repealed)
- 148.290 Adjustments and Reductions to Total Payments
- 148.295 Critical Hospital Adjustment Payments (CHAP)
- 148.296 Tertiary Care Adjustment Payments
- 148.297 Pediatric Outpatient Adjustment Payments
- 148.298 Pediatric Inpatient Adjustment Payments
- 148.300 Payment
- 148.310 Review Procedure
- 148.320 Alternatives
- 148.330 Exemptions
- 148.340 Subacute Alcoholism and Substance Abuse Treatment Services
- 148.350 Definitions (Repealed)
- 148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
- 148.368 Volume Adjustment (Repealed)
- 148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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- 148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
- 148.390 Hearings
- 148.400 Special Hospital Reporting Requirements
- 148.402 Medicaid Eligibility Payments (Repealed)
- 148.404 Medicaid High Volume Adjustment Payments (Repealed)
- 148.406 Intensive Care Adjustment Payments (Repealed)
- 148.408 Trauma Center Adjustment Payments (Repealed)
- 148.410 Psychiatric Rate Adjustment Payments (Repealed)
- 148.412 Rehabilitation Adjustment Payments (Repealed)
- 148.414 Supplemental Tertiary Care Adjustment Payments (Repealed)
- 148.416 Crossover Percentage Adjustment Payments (Repealed)
- 148.418 Long Term Acute Care Hospital Adjustment Payments (Repealed)
- 148.420 Obstetrical Care Adjustment Payments (Repealed)
- 148.422 Outpatient Access Payments (Repealed)
- 148.424 Outpatient Utilization Payments (Repealed)
- 148.426 Outpatient Complexity of Care Adjustment Payments (Repealed)
- 148.428 Rehabilitation Hospital Adjustment Payments (Repealed)
- 148.430 Perinatal Outpatient Adjustment Payments (Repealed)
- 148.432 Supplemental Psychiatric Adjustment Payments (Repealed)
- 148.434 Outpatient Community Access Adjustment Payments (Repealed)
- 148.440 High Volume Adjustment Payments
- 148.442 Inpatient Services Adjustment Payments
- 148.444 Capital Needs Payments
- 148.446 Obstetrical Care Payments
- 148.448 Trauma Care Payments
- 148.450 Supplemental Tertiary Care Payments
- 148.452 Crossover Care Payments
- 148.454 Magnet Hospital Payments
- 148.456 Ambulatory Procedure Listing Increase Payments
- 148.458 General Provisions
- 148.460 Catastrophic Relief Payments
- 148.462 Hospital Medicaid Stimulus Payments

## SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

## Section

- 148.500 Definitions
- 148.510 Reimbursement

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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## SUBPART D: STATE CHRONIC RENAL DISEASE PROGRAM

Section	
148.600	Definitions
148.610	Scope of the Program
148.620	Assistance Level and Reimbursement
148.630	Criteria and Information Required to Establish Eligibility
148.640	Covered Services

## SUBPART E: INSTITUTION FOR MENTAL DISEASES PROVISIONS FOR HOSPITALS

Section	
148.700	General Provisions

## SUBPART F: EMERGENCY PSYCHIATRIC DEMONSTRATION PROGRAM

Section	
148.800	General Provisions
148.810	Definitions
148.820	Individual Eligibility for the Program
148.830	Providers Participating in the Program
148.840	Stabilization and Discharge Practices
148.850	Medication Management
148.860	Community Connect IMD Hospital Payment
148.870	Community Connect TCM Agency Payment
148.880	Program Reporting
148.TABLE A	Renal Participation Fee Worksheet
148.TABLE B	Bureau of Labor Statistics Equivalence
148.TABLE C	List of Metropolitan Counties by SMSA Definition

**AUTHORITY:** Implementing and authorized by Articles III, IV, V and VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

**SOURCE:** Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg.

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## NOTICE OF ADOPTED AMENDMENTS

15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency expired July 29, 1995; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective November 28, 1995; amended at 20 Ill. Reg. 872, effective December 29, 1995; amended at 20 Ill. Reg. 7912, effective May 31, 1996; emergency amendment at 20 Ill. Reg. 9281, effective July 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 12510, effective September 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15722, effective November 27, 1996; amended at 21 Ill. Reg. 607, effective January 2, 1997; amended at 21 Ill. Reg. 8386, effective June 23, 1997; emergency amendment at 21 Ill. Reg. 9552, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9822, effective July 2, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 10147, effective August 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13349, effective September 23, 1997; emergency amendment at 21 Ill. Reg. 13675, effective September 27, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16161, effective November 26, 1997; amended at 22 Ill. Reg. 1408, effective December 29, 1997; amended at 22 Ill. Reg. 3083, effective January 26, 1998; amended at 22 Ill. Reg. 11514, effective June 22, 1998; emergency amendment at 22 Ill. Reg. 13070, effective July 1, 1998, for a maximum of 150 days; emergency

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amendment at 22 Ill. Reg. 15027, effective August 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16273, effective August 28, 1998; amended at 22 Ill. Reg. 21490, effective November 25, 1998; amended at 23 Ill. Reg. 5784, effective April 30, 1999; amended at 23 Ill. Reg. 7115, effective June 1, 1999; amended at 23 Ill. Reg. 7908, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8213, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12772, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13621, effective November 1, 1999; amended at 24 Ill. Reg. 2400, effective February 1, 2000; amended at 24 Ill. Reg. 3845, effective February 25, 2000; emergency amendment at 24 Ill. Reg. 10386, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11846, effective August 1, 2000; amended at 24 Ill. Reg. 16067, effective October 16, 2000; amended at 24 Ill. Reg. 17146, effective November 1, 2000; amended at 24 Ill. Reg. 18293, effective December 1, 2000; amended at 25 Ill. Reg. 5359, effective April 1, 2001; emergency amendment at 25 Ill. Reg. 5432, effective April 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6959, effective June 1, 2001; emergency amendment at 25 Ill. Reg. 9974, effective July 23, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 10513, effective August 2, 2001; emergency amendment at 25 Ill. Reg. 12870, effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002; amended at 25 Ill. Reg. 16087, effective December 1, 2001; emergency amendment at 26 Ill. Reg. 536, effective December 31, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 680, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 4825, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 4953, effective March 18, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 7786, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 7340, effective April 30, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 8395, effective May 28, 2002; emergency amendment at 26 Ill. Reg. 11040, effective July 1, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16612, effective October 22, 2002; amended at 26 Ill. Reg. 12322, effective July 26, 2002; amended at 26 Ill. Reg. 13661, effective September 3, 2002; amended at 26 Ill. Reg. 14808, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 14887, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17775, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 580, effective January 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 866, effective January 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 4386, effective February 24, 2003; emergency amendment at 27 Ill. Reg. 8320, effective April 28, 2003, for a maximum of 150 days; emergency amendment repealed at 27 Ill. Reg. 12121, effective July 10, 2003; amended at 27 Ill. Reg. 9178, effective May 28, 2003; emergency amendment at 27 Ill. Reg. 11041, effective July 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16185, effective October 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16268, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18843, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 1418, effective

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January 8, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 1766, effective January 10, 2004, for a maximum of 150 days; emergency expired June 7, 2004; amended at 28 Ill. Reg. 2770, effective February 1, 2004; emergency amendment at 28 Ill. Reg. 5902, effective April 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7101, effective May 3, 2004; amended at 28 Ill. Reg. 8072, effective June 1, 2004; emergency amendment at 28 Ill. Reg. 8167, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9661, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10157, effective July 1, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 12036, effective August 3, 2004, for a maximum of 150 days; emergency expired December 30, 2004; emergency amendment at 28 Ill. Reg. 12227, effective August 6, 2004, for a maximum of 150 days; emergency expired January 2, 2005; amended at 28 Ill. Reg. 14557, effective October 27, 2004; amended at 28 Ill. Reg. 15536, effective November 24, 2004; amended at 29 Ill. Reg. 861, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2026, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 5514, effective April 1, 2005; emergency amendment at 29 Ill. Reg. 5756, effective April 8, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 11622, effective July 5, 2005, for the remainder of the 150 days; amended at 29 Ill. Reg. 8363, effective June 1, 2005; emergency amendment at 29 Ill. Reg. 10275, effective July 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12568, effective August 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 15629, effective October 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19973, effective November 23, 2005; amended at 30 Ill. Reg. 383, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 955, effective January 9, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 2827, effective February 24, 2006; emergency amendment at 30 Ill. Reg. 7786, effective April 10, 2006, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 30 Ill. Reg. 12400, effective July 1, 2006, for the remainder of the 150 days; emergency expired September 6, 2006; amended at 30 Ill. Reg. 8877, effective May 1, 2006; amended at 30 Ill. Reg. 10393, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11815, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18672, effective November 27, 2006; emergency amendment at 31 Ill. Reg. 1602, effective January 1, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 1997, effective January 15, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 5596, effective April 1, 2007; amended at 31 Ill. Reg. 8123, effective May 30, 2007; amended at 31 Ill. Reg. 8508, effective June 1, 2007; emergency amendment at 31 Ill. Reg. 10137, effective July 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11688, effective August 1, 2007; amended at 31 Ill. Reg. 14792, effective October 22, 2007; amended at 32 Ill. Reg. 312, effective January 1, 2008; emergency amendment at 32 Ill. Reg. 518, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 2993, effective February 16, 2008, for a maximum of 150 days; amended at 32 Ill.

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Reg. 8718, effective May 29, 2008; amended at 32 Ill. Reg. 9945, effective June 26, 2008; emergency amendment at 32 Ill. Reg. 10517, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 33 Ill. Reg. 501, effective December 30, 2008; preemptory amendment at 33 Ill. Reg. 1538, effective December 30, 2008; emergency amendment at 33 Ill. Reg. 5821, effective April 1, 2009, for a maximum of 150 days; emergency expired August 28, 2009; amended at 33 Ill. Reg. 13246, effective September 8, 2009; emergency amendment at 34 Ill. Reg. 15856, effective October 1, 2010, for a maximum of 150 days; emergency expired February 27, 2011; amended at 34 Ill. Reg. 17737, effective November 8, 2010; amended at 35 Ill. Reg. 420, effective December 27, 2010; amended at 35 Ill. Reg. 10033, effective June 15, 2011; amended at 35 Ill. Reg. 16572, effective October 1, 2011; emergency amendment at 36 Ill. Reg. 10326, effective July 1, 2012 through June 30, 2013; emergency amendment to Section 148.70(g) suspended at 36 Ill. Reg. 13737, effective August 15, 2012; suspension withdrawn from Section 148.70(g) at 36 Ill. Reg. 18989, December 11, 2012; emergency amendment in response to Joint Committee on Administrative Rules action on Section 148.70(g) at 36 Ill. Reg. 18976, effective December 12, 2012 through June 30, 2013; emergency amendment to Section 148.140(b)(1)(F) suspended at 36 Ill. Reg. 13739, effective August 15, 2012; suspension withdrawn from Section 148.140(b)(1)(F) at 36 Ill. Reg. 14530, September 11, 2012; emergency amendment to Sections 148.140(b) and 148.190(a)(2) in response to Joint Committee on Administrative Rules action at 36 Ill. Reg. 14851, effective September 21, 2012 through June 30, 2013; amended at 37 Ill. Reg. 402, effective December 27, 2012; emergency rulemaking at 37 Ill. Reg. 5082, effective April 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 10432, effective June 27, 2013.

## SUBPART A: GENERAL PROVISIONS

**Section 148.70 Limitation On Hospital Services**

- a) Payment for inpatient hospital care in general and specialty hospitals, including psychiatric hospitals, shall be made only when it is recommended by a qualified physician, and the care is essential as determined by the appropriate utilization review authority. For hospitals or distinct part units reimbursed on a per diem basis under Sections 148.160 through 148.170 and 148.250 through 148.300, payment shall not exceed the number of days approved for the recipient's care by the appropriate utilization review authority (see Section 148.240). If Medicare benefits are not paid because of non-approval by the utilization review authority, payment shall not be made on behalf of the Department.
- b) For hospitals or distinct part units reimbursed on a per case basis, payment for inpatient hospital services shall be made in accordance with 89 Ill. Adm. Code

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- c) For hospitals, or distinct part units reimbursed on a per diem basis, under Sections 148.160 through 148.170 and 148.250 through 148.300, payment for inpatient hospital services shall be made based on calendar days. The day of admission shall be counted. The day of discharge shall not be counted. An admission with discharge on the same day shall be counted as one day. If a recipient is admitted, discharged and re-admitted on the same day, only one day shall be counted.
- d) In obstetrical cases, payment for services to both the mother and the newborn child shall be made at one per diem rate, or one per case rate, whichever is applicable. Only in instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery, shall payment be made in the child's name separately.
- e) Payment for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1), shall be made only when such services have been provided in accordance with federal regulations at 42 CFR 441, subparts Subparts C and D.
- f) Payment for transplantation costs (with the exception of kidney and cornea transplants), including organ acquisition costs, shall be made only when provided by an approved transplantation center as described in Section 148.82. Payment for kidney and cornea transplantation costs does not require enrollment as an approved transplantation center and is only provided to hospitals reimbursed on a per case basis in accordance with 89 Ill. Adm. Code 149.
- g) Effective with inpatient hospital admissions on or after July 1, 2012, the Department shall reduce the payment for a claim that indicates the occurrence of a provider preventable condition during the admission as specified in this subsection (g).
- 1) Until such time as the All Patient Refined Diagnosis Related Groups (APR-DRG) is implemented by the Department in rule, as authorized by Section 14-11 of the Public Aid Code, the Department shall reduce each claim that indicates the occurrence of a health care acquired condition (HAC) by \$900.
  - 2) After the APR-DRG is implemented by the Department in rule, as

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authorized by Section 14-11 of the Public Aid Code, the Department shall reduce each claim by the amount that the payment on the claim is increased directly due to the occurrence of and treatment for the HAC.

- 3) The Department shall not pay for services related to Other Provider Preventable Conditions (OPPCs).
- 4) For HACs, hospitals shall code inpatient claims with a Present on Admission (POA) indicator for principal and secondary diagnosis codes billed. For OPPCs, hospitals shall submit claims to report these incidents and will be instructed to populate the inpatient claims with specific supplementary diagnosis coding.
- 5) Definitions. As used in this subsection (g), the following terms are defined as follows:

"Provider Preventable Condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 (2012) or an Other Provider Preventable Condition.

"Other Provider Preventable Condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.
- h) Payment for caesarean sections shall be at the normal vaginal delivery rate unless a caesarean section is medically necessary.

(Source: Amended at 37 Ill. Reg. 10432, effective June 27, 2013)

## SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

**Section 148.117 Outpatient Assistance Adjustment Payments**

- a) Qualifying Criteria. Outpatient Assistance Adjustment Payments, as described in subsection (b) of this Section, shall be made to Illinois hospitals meeting one of the criteria identified in this subsection (a):
  - 1) A hospital that qualifies for Disproportionate Share Adjustment Payments for rate year 2007, as defined in Section 148.120, has an emergency care

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percentage greater than 70% and has provided greater than 10,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

- 2) A general acute care hospital that qualifies for Disproportionate Share Adjustment Payments for rate year 2007, as defined in Section 148.120, has an emergency care percentage greater than 85%.
- 3) A general acute care hospital that does not qualify for Medicaid Percentage Adjustment Payments for rate year 2007, as defined in Section 148.122, located in Cook County, outside the City of Chicago, has an emergency care percentage greater than 63%, has provided more than 10,750 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year and has provided more than 325 Medicaid surgical group outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 4) A general acute care hospital located outside of Cook County that qualifies for Medicaid Percentage Adjustment Payments for rate year 2007 as defined in Section 148.122, is a trauma center recognized by the Illinois Department of Public Health (DPH) as of July 1, 2006, has an emergency care percentage greater than 58%, and has provided more than 1,000 Medicaid Non-emergency/Screening outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 5) A hospital that has an MIUR of greater than 50% and an emergency care percentage greater than 80%, and that provided more than 6,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 6) A hospital that has an MIUR of greater than 70% and an emergency care percentage greater than 90%.
- 7) A general acute care hospital, not located in Cook County, that is not a trauma center recognized by DPH as of July 1, 2006 and did not qualify for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Section 148.122, has an MIUR of greater than 25% and an emergency care percentage greater than 50%, and that provided more than

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8,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

- 8) A general acute care hospital, not located in Cook County, that is a Level I trauma center recognized by DPH as of July 1, 2006, has an emergency care percentage greater than 50%, and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services, including more than 1,000 non-emergency screening outpatient ambulatory procedure listing services, in the outpatient assistance base year.
- 9) A general acute care hospital, not located in Cook County, that qualified for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Section 148.122, has an emergency care percentage greater than 55%, and provided more than 12,000 Medicaid outpatient ambulatory procedure listing services, including more than 600 surgical group outpatient ambulatory procedure listing services and 7,000 emergency services in the outpatient assistance base year.
- 10) A general acute care hospital that has an emergency care percentage greater than 75% and provided more than 15,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 11) A rural hospital that has an MIUR of greater than 40% and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 12) A general acute care hospital, not located in Cook County, that is a trauma center recognized by DPH as of July 1, 2006, had more than 500 licensed beds in calendar year 2005, and provided more than 11,000 Medicaid outpatient ambulatory procedure listing services, including more than 950 surgical group outpatient ambulatory procedure listing services, in the outpatient assistance base year.
- 13) A general acute care hospital located outside of Illinois that provided more than 300 high tech diagnostic Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

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- 14) A general acute care hospital is recognized as a Level I trauma center by DPH on the first day of the OAAP rate period, has Emergency Level I services greater than 2,000, Emergency Level II services greater than 8,000, and greater than 19,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- b) Outpatient Assistance Adjustment Payments
- 1) For hospitals qualifying under subsection (a)(1), the rate is \$139.00.
  - 2) For hospitals qualifying under subsection (a)(2), the rate is \$850.00.
  - 3) For hospitals qualifying under subsection (a)(3), the rate is \$425.00.
  - 4) For hospitals qualifying under subsection (a)(4), the rate is \$665.00 through ~~December 31, 2014~~~~June 30, 2012~~. For dates of service on or after ~~January 1, 2015~~~~July 1, 2012~~, the rate is \$375.00.
  - 5) For hospitals qualifying under subsection (a)(5), the rate is \$250.00.
  - 6) For hospitals qualifying under subsection (a)(6), the rate is \$336.25.
  - 7) For hospitals qualifying under subsection (a)(7), the rate is \$110.00
  - 8) For hospitals qualifying under subsection (a)(8), the rate is \$200.00.
  - 9) For hospitals qualifying under subsection (a)(9), the rate is \$128.50 through June 30, 2010. For dates of service on or after July 1, 2010 through ~~December 31, 2014~~~~June 30, 2012~~, this rate shall be increased by \$74.00, to \$202.50. For dates of service on or after ~~January 1, 2015~~~~July 1, 2012~~, the rate is \$48.50.
  - 10) For hospitals qualifying under subsection (a)(10), the rate is \$135.00. For dates of service on or after July 1, 2010 through ~~December 31, 2014~~~~June 30, 2012~~, this rate shall be increased by \$70.00, to \$205.00. For dates of service on or after January 1, 2015, the rate is \$135.00.
  - 11) For hospitals qualifying under subsection (a)(11), the rate is \$65.00.

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- 12) For hospitals qualifying under subsection (a)(12), the rate is \$90.00.
  - 13) For hospitals qualifying under subsection (a)(13) that have an emergency care percentage greater than 19% but less than 25%, the rate is \$141.00. For hospitals qualifying under subsection (a)(13) that have an emergency care percentage greater than 25%, the rate is \$494.00.
  - 14) For hospitals qualifying under subsection (a)(14), the rate is \$47.00 for dates of service on or after July 1, 2010 through ~~December 31, 2014~~June 30, 2012. For dates of service on or after ~~January 1, 2015~~July 1, 2012, the rate is \$0.00.
- c) Payment to a Qualifying Hospital
- 1) The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by the Medicaid outpatient ambulatory procedure listing services in the outpatient assistance adjustment base year.
  - 2) For the outpatient assistance adjustment period for fiscal year 2010 and after, total payments will equal the amount determined using the methodologies described in subsection (c)(1) of this Section and shall be paid to the hospital, at least, on a quarterly basis.
  - 3) Payments described in this Section are subject to federal approval.
- d) Definitions
- 1) "Emergency care percentage" means a fraction, the numerator of which is the total Group 3 ambulatory procedure listing services as described in Section 148.140(b)(1)(C), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006, and the denominator of which is the total ambulatory procedure listing services as described in Section 148.140(b)(1), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006.

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- 2) "General acute care hospital" is a hospital that does not meet the definition of a hospital contained in 89 Ill. Adm. Code 149.50(c).
- 3) "Outpatient Ambulatory Procedure Listing Payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.
- 4) "Outpatient assistance year" means, beginning January 1, 2007, the 6-month period beginning on January 1, 2007 and ending June 30, 2007, and beginning July 1, 2007, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 5) "Outpatient assistance base period" means the 12-month period beginning on July 1, 2004 and ending June 30, 2005.
- 6) "Surgical group outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b)(1)(A), excluding services for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.
- 7) "Non-emergency/screening outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b)(1)(C)(iii), excluding services for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.
- 8) "High tech diagnostic Medicaid outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure

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listing services described in Section 148.140(b)(1)(B)(ii), excluding services for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.

- e) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 must be a Coordinated Care Participating Hospital as defined in Section 148.295(g)(5). This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area.

(Source: Amended at 37 Ill. Reg. 10432, effective June 27, 2013)

**Section 148.126 Safety Net Adjustment Payments**

- a) Qualifying criteria: Safety net adjustment payments shall be made to a qualifying hospital, as defined in this subsection (a), unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria:
- 1) The hospital has, as provided in subsection (e)(6) of this Section, an MIUR equal to or greater than 40 percent.
  - 2) The hospital has the highest number of obstetrical care days in the safety net hospital base year.
  - 3) The hospital is, as of October 1, 2001, a sole community hospital, as defined by the United States Department of Health and Human Services (42 CFR 412.92).
  - 4) The hospital is, as of October 1, 2001, a rural hospital, as described in Section 148.25(g)(3), that meets all of the following criteria:

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- A) Has an MIUR greater than 33 percent.
  - B) Is designated a perinatal level two center by the Illinois Department of Public Health.
  - C) Has fewer than 125 licensed beds.
- 5) The hospital is a rural hospital, as described in Section 148.25(g)(3).
- 6) The hospital meets all of the following criteria:
- A) Has an MIUR greater than 30 percent.
  - B) Had an occupancy rate greater than 80 percent in the safety net hospital base year.
  - C) Provided greater than 15,000 total days in the safety net hospital base year.
- 7) The hospital meets all of the following criteria:
- A) Does not already qualify under subsections (a)(1) through (a)(6) of this Section.
  - B) Has an MIUR greater than 25 percent.
  - C) Had an occupancy rate greater than 68 percent in the safety net hospital base year.
  - D) Provided greater than 12,000 total days in the safety net hospital base year.
- 8) The hospital meets all of the following criteria in the safety net base year:
- A) Is a rural hospital, as described in Section 148.25(g)(3).
  - B) Has an MIUR greater than 18 percent.

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- C) Has a combined MIUR greater than 45 percent.
  - D) Has licensed beds less than or equal to 60.
  - E) Provided greater than 400 total days.
  - F) Provided fewer than 125 obstetrical care days.
- 9) The hospital meets all of the following criteria in the safety net base year:
- A) Is a psychiatric hospital, as described in 89 Ill. Adm. Code 149.50(c)(1).
  - B) Has licensed beds greater than 120.
  - C) Has an average length of stay less than ten days.
- 10) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(9) of this Section.
  - B) Has an MIUR greater than 17 percent.
  - C) Has licensed beds greater than 450.
  - D) Has an average length of stay less than four days.
- 11) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(10) of this Section.
  - B) Has an MIUR greater than 21 percent.
  - C) Has licensed beds greater than 350.
  - D) Has an average length of stay less than 3.15 days.

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- 12) The hospital meets all of the following criteria in the safety net base year:
  - A) Does not already qualify under subsections (a)(1) through (a)(11) of this Section.
  - B) Has an MIUR greater than 34 percent.
  - C) Has licensed beds greater than 350.
  - D) Is designated a perinatal Level II center by the Illinois Department of Public Health.
- 13) The hospital meets all of the following criteria in the safety net base year:
  - A) Does not already qualify under subsections (a)(1) through (a)(12) of this Section.
  - B) Has an MIUR greater than 35 percent.
  - C) Has an average length of stay less than four days.
- 14) The hospital meets all of the following criteria in the safety net base year:
  - A) Does not already qualify under subsections (a)(1) through (a)(13) of this Section.
  - B) Has a Combined MIUR greater than 25 percent.
  - C) Has an MIUR greater than 12 percent.
  - D) Is designated a perinatal Level II center by the Illinois Department of Public Health.
  - E) Has licensed beds greater than 400.
  - F) Has an average length of stay less than 3.5 days.
- 15) A hospital provider that would otherwise be excluded from payment by subsection (a) because it does not operate a comprehensive emergency

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room, if the hospital provider operates within 1 mile of an affiliate hospital provider that is owned and controlled by the same governing body that operates a comprehensive emergency room, as defined in 77 Ill. Adm. Code 250.710(a), and the provider operates a standby emergency room, as defined in 77 Ill. Adm. Code 250.710(c), and functions as an overflow emergency room for its affiliate hospital provider.

- 16) The hospital has an MIUR greater than 90% in the safety net hospital base year.
- 17) The hospital meets all of the following criteria in the safety net base year:
  - A) Does not already qualify under subsections (a)(1) through (a)(16) of this Section.
  - B) Is located outside HSA 6.
  - C) Has an MIUR greater than 16%.
  - D) Has licensed beds greater than 475.
  - E) Has an average length of stay less than five days.
- 18) The hospital meets all of the following criteria in the safety net base year:
  - A) Provided greater than 5,000 obstetrical care days.
  - B) Has a combined MIUR greater than 80%.
- 19) The hospital meets all of the following criteria in the safety net base year:
  - A) Does not already qualify under subsections (a)(1) through (a)(18) of this Section.
  - B) Has a CMIUR greater than 28 percent.
  - C) Is designated a perinatal Level II center by the Illinois Department of Public Health.

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- D) Has licensed beds greater than 320.
- E) Had an occupancy rate greater than 37 percent in the safety net hospital base year.
- F) Has an average length of stay less than 3.1 days.

20) The hospital meets all of the following criteria in the safety net base year:

- A) Does not already qualify under subsections (a)(1) through (a)(19) of this Section.
- B) Is a general acute care hospital.
- C) Is designated a perinatal Level II center by the Illinois Department of Public Health.
- D) Provided greater than 1,000 rehabilitation days in the safety net hospital base year.

21) The hospital meets all of the following criteria in the safety net base year:

- A) Qualifies as a children's hospital under subsection (c)(1) of this Section.
- B) Has an average length of stay less than 3.25 days.
- C) Provided greater than 1,000 total days in the safety net hospital base year.

b) The following five classes of hospitals are ineligible for safety net adjustment payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4), subsections (a)(6) through (a)(8), subsections (a)(10) through (a)(15) and subsections (a)(17) through (a)(19) of this Section:

- 1) Hospitals located outside of Illinois.
- 2) County-owned hospitals, as described in Section 148.25(b)(1)(A).

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- 3) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
  - 4) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(c)(1).
  - 5) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(c)(4).
- c) Safety Net Adjustment Rates
- 1) For a hospital qualifying under subsection (a)(1) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:
    - A) A qualifying hospital – \$15.00.
    - B) A rehabilitation hospital, as described in 89 Ill. Adm. Code 149.50(c)(2) – \$20.00.
    - C) A children's hospital, as described in 89 Ill. Adm. Code 149.50(c)(3) – \$20.00.
    - D) A children's hospital that has an MIUR greater than or equal to 80 per centum that is:
      - i) Located within HSA 6 or HSA 7 – \$296.00.
      - ii) Located outside HSA 6 or HSA 7 – \$35.00.
    - E) A children's hospital that has an MIUR less than 80 per centum, but greater than or equal to 60 per centum, that is:
      - i) Located within HSA 6 or HSA 7 – \$35.00.
      - ii) Located outside HSA 6 or HSA 7 – \$15.00.
    - F) A children's hospital that has an MIUR less than 60 per centum, but greater than or equal to 45 per centum, that is:
      - i) Located within HSA 6 or HSA 7 – \$12.00.

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- ii) Located outside HSA 6 or HSA 7 – \$5.00.
- G) A children's hospital with more than 25 graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory" – \$160.25.
- H) A children's hospital that is a rural hospital – \$145.00.
- I) A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital that is located in HSA 6 and that:
  - i) Provides obstetrical care – \$10.00.
  - ii) Has at least one graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory" – \$5.00.
  - iii) Has at least one obstetrical graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory" – \$5.00.
  - iv) Provided more than 5,000 obstetrical days during the safety net hospital base year – \$35.00.
  - v) Provided fewer than 4,000 obstetrical days during the safety net hospital base year and its average length of stay is: less than or equal to 4.50 days – \$5.00; less than 4.00 days – \$5.00; less than 3.75 days – \$5.00.
  - vi) Provides obstetrical care and has an MIUR greater than 65 percent – \$11.00.
  - vii) Has greater than 700 licensed beds – \$37.75.
- J) A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6, that has an MIUR greater than 50 per centum, and that:

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- i) Provides obstetrical care – \$280.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$70.00.
    - ii) Does not provide obstetrical care – \$120.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$30.00.
    - iii) Is a trauma center, recognized by the Illinois Department of Public Health (DPH), as of July 1, 2005 – \$173.50.
  - K) A qualifying hospital that provided greater than 35,000 total days in the safety net hospital base year – \$43.25.
  - L) A qualifying hospital with two or more graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory", with an average length of stay fewer than 4.00 days – \$48.00.
- 2) For a hospital qualifying under subsection (a)(2) of this Section, the rate shall be \$123.00 for dates of service through March 2, 2013. The rate shall be increased by \$121.00, to \$244.00, for dates of service on or after March 3, 2013 through June 30, 2013. For dates of service on or after July 1, 2013, the rate shall be \$123.00.
- 3) For a hospital qualifying under subsection (a)(3) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:
- A) A qualifying hospital – \$40.00.
  - B) A hospital that has an average length of stay of fewer than 4.00 days, and:
    - i) More than 150 licensed beds – \$20.00.
    - ii) Fewer than 150 licensed beds – \$40.00.
  - C) A qualifying hospital with the lowest average length of stay –

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\$15.00.

- D) A hospital that has a CMIUR greater than 65 per centum – \$35.00.
- E) A hospital that has fewer than 25 total admissions in the safety net hospital base year – \$160.00.
- 4) For a hospital qualifying under subsection (a)(4) of this Section, the rate shall be \$110.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$55.00.
- 5) For a hospital qualifying under subsection (a)(5) of this Section, the rate is the sum of the amounts for each of the following for which it qualifies, divided by the hospital's total days:
- A) The hospital that has the highest number of obstetrical care admissions – \$30,840.00.
- B) The greater of:
- i) The product of \$115.00 multiplied by the number of obstetrical care admissions.
- ii) The product of \$11.50 multiplied by the number of general care admissions.
- 6) For a hospital qualifying under subsection (a)(6) of this Section, the rate is \$56.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$53.00.
- 7) For a hospital qualifying under subsection (a)(7) of this Section, the rate is \$315.50 through ~~December 31, 2014~~ ~~June 30, 2012~~ if federal approval is received by the Department for that rate; otherwise, the rate shall be \$210.50. For dates of service on or after ~~January 1, 2015~~ ~~July 1, 2012~~, the rate is \$210.50.
- 8) For a hospital qualifying under subsection (a)(8) of this Section, the rate is \$124.50.

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- 9) For a hospital qualifying under subsection (a)(9) of this Section, the rate is \$133.00. For dates of service on or after July 1, 2010 through December 31, 2014~~June 30, 2012~~, this rate shall be increased by \$72.00, to \$205.00. For dates of service on or after January 1, 2015~~July 1, 2012~~, the rate is \$85.50.
- 10) For a hospital qualifying under subsection (a)(10) of this Section, the rate is \$13.75. For dates of service on or after July 1, 2010 through December 31, 2014~~June 30, 2012~~, this rate shall be increased by \$25.00, to \$38.75. For dates of service on or after January 1, 2015~~July 1, 2012~~, the rate is \$13.75.
- 11) For a hospital qualifying under subsection (a)(11) of this Section, the rate is \$421.00 through December 31, 2014~~June 30, 2012~~. For dates of service on or after January 1, 2015~~July 1, 2012~~, the rate is \$39.50.
- 12) For a hospital qualifying under subsection (a)(12) of this Section, the rate is \$240.50 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$120.25.
- 13) For a hospital qualifying under subsection (a)(13) of this Section, for dates of service on or after April 1, 2009, the rate is \$815.00.
- 14) For a hospital qualifying under subsection (a)(14) of this Section, the rate is \$443.75 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$343.75.
- 15) For a hospital qualifying under subsection (a)(16) of this Section, the rate is \$39.50.
- 16) For a hospital qualifying under subsection (a)(17) of this Section, the rate is \$69.00. This reimbursement rate is contingent on federal approval.
- 17) For a hospital qualifying under subsection (a)(18) of this Section, the rate is \$56.00 through December 31, 2014~~June 30, 2012~~. For dates of service on or after January 1, 2015~~July 1, 2012~~, the rate is \$16.00. This reimbursement rate is contingent on federal approval.

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- 18) For a hospital qualifying under subsection (a)(19) of this Section, the rate is \$229.00. For dates of service on or after July 1, 2010 through December 31, 2014~~June 30, 2012~~, this rate shall be increased by \$113.00, to \$342.00. For dates of service on or after January 1, 2015~~July 1, 2012~~, the rate is \$145.00.
- 19) For a hospital qualifying under subsection (a)(20) of this Section, the rate is \$71.00 through December 31, 2014~~June 30, 2012~~. For dates of service on or after January 1, 2015~~July 1, 2012~~, the rate is \$0.00.
- 20) For a hospital qualifying under subsection (a)(21) of this Section, the rate is \$1986.00 for dates of service on or after March 3, 2013 through June 30, 2013. For dates of service on or after July 1, 2013, the rate is \$0.00.

## d) Payment to a Qualifying Hospital

- 1) The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by two multiplied by total days.
- 2) For the safety net adjustment period occurring in State fiscal year 2011, total payments will be determined through application of the methodologies described in subsection (c) of this Section.
- 3) For safety net adjustment periods occurring after State fiscal year 2010, total payments made under this Section shall be paid in installments on, at least, a quarterly basis.

## e) Definitions

- 1) "Average length of stay" means, for a given hospital, a fraction in which the numerator is the number of total days and the denominator is the number of total admissions.
- 2) "CMIUR" means, for a given hospital, the sum of the MIUR plus the Medicaid obstetrical inpatient utilization rate, determined as of October 1, 2001, as defined in Section 148.120(i)(6).
- 3) "General care admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under

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Title XIX of the Social Security Act, as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department by June 30, 2001, excluding admissions for: obstetrical care, as defined in subsection (e)(7) of this Section; normal newborns; psychiatric care; physical rehabilitation; and those covered in whole or in part by Medicare (Medicaid/Medicare crossover admissions).

- 4) "HSA" means Health Service Area, as defined by the Illinois Department of Public Health.
- 5) "Licensed beds" means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."
- 6) "MIUR", for a given hospital, has the meaning as defined in Section 148.120(i)(5) and shall be determined in accordance with Section 148.120(c) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for safety net adjustment payments in the Safety Net Adjustment Period.
- 7) "Obstetrical care admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department's claims data, for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001, and were assigned by the Department a diagnosis related grouping (DRG) code of 370 through 375.
- 8) "Obstetrical care days" means, for a given hospital, days of hospital inpatient service associated with the obstetrical care admissions described in subsection (e)(7) of this Section.
- 9) "Occupancy rate" means, for a given hospital, a fraction, the numerator of which is the hospital's total days, excluding long term care and substance

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abuse days, and the denominator of which is the hospital's total beds, excluding long term care and substance abuse beds, multiplied by 365 days. The data used for calculation of the hospital occupancy rate is as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".

- 10) "Safety net hospital base year" means the 12-month period beginning on July 1, 1999, and ending on June 30, 2000.
  - 11) "Safety net adjustment period" means, beginning July 1, 2002, the 12 month period beginning on July 1 of a year and ending on June 30 of the following year.
  - 12) "Total admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover admissions), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.
  - 13) "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.
- f) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 must be a Coordinated Care Participating Hospital as defined in Section 148.295(g)(5). The payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area.

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(Source: Amended at 37 Ill. Reg. 10432, effective June 27, 2013)

**Section 148.140 Hospital Outpatient and Clinic Services**

- a) Fee-For-Service Reimbursement
  - 1) Reimbursement for hospital outpatient services shall be made on a fee-for-service basis, except for:
    - A) Those services that meet the definition of the Ambulatory Procedure Listing (APL) as described in subsection (b) of this Section.
    - B) End stage renal disease treatment (ESRDT) services, as described in subsection (c) of this Section.
    - C) Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D).
    - D) Those services provided by a Critical Clinic Provider as described in subsection (e) of this Section.
  - 2) Except for the procedures under the APL groupings described in subsection (b) of this Section, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.
  - 3) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rate described in subsection (a)(2) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
    - A) The reimbursement rates described in subsection (a)(2) of this

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Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 4) Maternal and Child Health Program rates, as described in 89 Ill. Adm. Code 140, Table M, shall be paid to Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A) and Section 148.25(b)(5)(A), Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and Section 148.25(b)(5)(B), and Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C), and Section 148.25(b)(5)(C). Maternal and Child Health Program rates shall also be paid to Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), for covered services as described in 89 Ill. Adm. Code 140.462(e)(3), that are provided to non-assigned Maternal and Child Health Program clients, as described in 89 Ill. Adm. Code 140.464(b)(1).
- 5) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b)(2) for assigned clients.
- 6) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- 7) With the exception of the retrospective adjustment described in subsection (a)(3) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this Section.
- b) Ambulatory Procedure Listing (APL)  
Effective ~~July 1, 2012~~~~January 1, 2006~~, the Department will reimburse hospitals

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for certain hospital outpatient procedures as described in subsection (b)(1) of this Section.

- 1) **APL Groupings**  
Under the APL, a list was developed that defines those technical procedures that require the use of the hospital outpatient setting, its technical staff or equipment. These procedures are separated into separate groupings based upon the complexity and historical costs of the procedures. The groupings are as follows:
  - A) **Surgical Groups**
    - i) Surgical group 1(a) consists of intense surgical procedures. Group 1(a) surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills and highly technical operating room personnel using high technology equipment. The rate for this surgical procedure group shall be \$1,794.00.
    - ii) Surgical group 1(b) consists of moderately intense surgical procedures. Group 1(b) surgeries generally require the use of an operating room suite or an emergency room treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment. The rate for this surgical procedure group shall be \$1,049.00.
    - iii) Surgical group 1(c) consists of low intensity surgical procedures. Group 1(c) surgeries may be done in an operating suite or an emergency room and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons. The rate for this surgical procedure group shall be \$752.00.
    - iv) Surgical group 1(d) consists of surgical procedures of very low intensity. Group 1(d) surgeries may be done in an operating room or emergency room, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures. Certain dental

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procedures performed by dentists are included in this group. In order for a dental procedure to be eligible for reimbursement in the outpatient setting, the following criteria must be met: patient requires general anesthesia or conscious sedation; patient has a medical condition that places the patient at an increased surgical risk, such as, but not limited to, cardiopulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or the patient cannot be safely managed in an office setting because of behavioral, developmental, or mental disorder. The rate for this surgical procedure group shall be \$287.00.

## B) Diagnostic and Therapeutic Groups

- i) Diagnostic and therapeutic group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2(a) procedures are typically invasive and must be administered by a physician. The rate for this surgical procedure group shall be \$941.00.
- ii) Diagnostic and therapeutic group 2(b) consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2(b) procedures typically include radiological consultation or a diagnostic study. The rate for this procedure group shall be \$304.00.
- iii) Diagnostic and therapeutic group 2(c) consists of other diagnostic tests. Group 2(c) procedures are generally non-invasive and may be administered by a technician and monitored by a physician. The rate for this procedure group shall be \$176.00.
- iv) Diagnostic and therapeutic group 2(d) consists of therapeutic procedures. Group 2(d) procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such

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procedures. The rate for this procedure group shall be \$136.00.

- C) Group 3 reimbursement for services provided in a hospital emergency department will be made in accordance with one of the three levels described in this Section. Emergency Services mean those services that are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The determination of the level of service reimbursable by the Department shall be based upon the circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.
- i) Emergency Level I refers to Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries that pose an immediate significant threat to life or physiologic function or requires an intense level of physician or nursing intervention. An "intense level" is defined as more than two hours of documented one-on-one nursing care or interactive treatment. The rate for this service shall be \$181.00.
  - ii) Emergency Level II refers to Emergency Services that do not meet the definition in this Section of Emergency Level I care, but that are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity. The rate for this service shall be \$67.00.
  - iii) Non-Emergency/Screening Level means those services provided in the hospital emergency department that do not

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meet the requirements of Emergency Level I or II stated in this Section. For such care, the Department will reimburse the hospital either applicable current FFS rates for the services provided or a screening fee, but not both. The rate for this service shall be \$26.00.

- D) Group 4 for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting that provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. Observation services will be reimbursed under one of three categories:
- i) for at least 60 minutes but less than six hours and 31 minutes of services, the rate shall be \$74.00;
  - ii) for at least six hours and 31 minutes but less than 12 hours and 31 minutes of services, the rate shall be \$222.00; or
  - iii) for at least 12 hours and 31 minutes or more of services, the rate shall be \$443.00.
- E) Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services. Under this group, the Department will reimburse, at different rates, Type A and Type B Psychiatric Clinic Services, as defined in Section 148.40(d)(1). A different rate will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
- i) The rate for Type A psychiatric clinic services shall be \$68.00.

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- ii) The rate for Type A psychiatric clinic services provided by a Children's Hospital shall be \$102.00.
  - iii) The rate for Type B psychiatric clinic services shall be \$101.00.
  - iv) The rate for Type B psychiatric clinic services provided by a Children's Hospital shall be \$102.00.
- F) ~~Effective July 1, 2012, subject to 89 Ill. Adm. Code 152.100, Group 6 for physical rehabilitation services shall no longer be in effect and outpatient physical rehabilitation services provided by a hospital shall be reimbursed through the non-institutional payment system, but will be reimbursed as a hospital service at the following rates of reimbursement: Group 6 for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services. Under this group, the Department will reimburse for services provided by a hospital enrolled with the Department to provide outpatient physical rehabilitation services at a different rate than will be reimbursed for physical rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation services. A different rate will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).~~
- i) The rate for rehabilitation services provided by a hospital enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00.
  - ii) The rate for rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation shall be \$115.00.
  - iii) The rate for rehabilitation services provided by children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3)(A), Children's Hospitals shall be \$130.00.
- 2) Each of the groups described in subsection (b)(1) of this Section will be reimbursed by the Department considering the following:

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- A) The Department will provide cost outlier payments for specific devices and drugs associated with specific APL procedures. Such payments will be made if:
- i) The device or drug is on an approved list maintained by the Department. In order to be approved, the Department will consider requests from medical providers and shall base its decision on medical appropriateness of the device or drug and the costs of such device or drug; and
  - ii) The provision of such devices or drugs is deemed to be medically appropriate for a specific client, as determined by the Department's physician consultants.
- B) Additional payment for such devices or drugs, as described in subsection (b)(2)(A) of this Section, will require prior authorization by the Department unless it is determined by the Department's professional medical staff that prior authorization is not warranted for a specific device or drug. When such prior authorization has been denied for a specific device or drug, the decision may be appealed as allowed by 89 Ill. Adm. Code 102.80(a)(7) and in accordance with the provisions for assistance appeals at 89 Ill. Adm. Code 104.
- C) The amount of additional payment for devices or drugs, as described in subsection (b)(2)(A) of this Section, will be based on the following methodology:
- i) The product of a cost to charge ratio that, in the case of cost reporting hospitals as described in Section 148.130(d), or in the case of other non-cost reporting providers, equals 0.5 multiplied by the provider's total covered charges on the qualifying claim, less the APL payment rate multiplied by four;
  - ii) If the result of subsection (b)(2)(C)(i) of this Section is less than or equal to zero, no additional payment will be made. If the result is greater than zero, the additional payment will

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equal the result of subsection (b)(2)(C)(i) of this Section, multiplied by 80 percent. In such cases, the provider will receive the sum of the APL payment and the additional payment for such high cost devices or drugs.

- D) For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amounts described in subsection (b)(1) of this Section multiplied by a factor of 2.72, ~~except that physical rehabilitation services provided by a general care hospital not enrolled with the Department to provide outpatient physical rehabilitation services shall be reimbursed at a rate of \$230.00 and the reimbursement rate for Type B psychiatric clinic services shall be \$224.00.~~
- E) Reimbursement rates for hospitals not required to file an annual cost report with the Department may be lower than those listed in this Section.
- F) Reimbursement for each APL group described in this subsection (b) shall be all-inclusive for all services provided by the hospital, regardless of the amount charged by a hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician providing direct patient care who is salaried by the hospital; chemotherapy services provided in conjunction with radiation therapy services; and physical rehabilitation, occupational or speech therapy services provided in conjunction with any APL group described in this subsection (b); ~~and occupational or speech therapy services provided in conjunction with rehabilitation services as described in subsection (b)(1)(F) of this Section.~~ For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or

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certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.

- 3) The assignment of procedure codes to each of the reimbursement groups in subsection (b)(1)(A) through (b)(1)(E) of this Section are detailed in the Department's Hospital Handbook and in notices to providers.
- 4) A one-time fiscal year 2000 payment will be made to hospitals. Payment will be based upon the services, specified in this Section, provided on or after July 1, 1998, and before July 1, 1999, which were submitted to the Department and determined eligible for payment (adjudicated) by the Department on or prior to April 30, 2000, excluding services for Medicare/Medicaid crossover claims and claims that resulted in a zero payment by the Department. A one-time amount of:
  - A) \$27.75 will be paid for each service for procedure code W7183 (Psychiatric clinic Type A for adults).
  - B) \$24.00 will be paid for each service for APL Group 5 (Psychiatric clinic Type A only) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
  - C) \$15.00 will be paid for each service for APL Group 6 (Physical rehabilitation services) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
- 5) County Facility Outpatient Adjustment
  - A) Effective for services provided on or after July 1, 1995, county owned hospitals in an Illinois county with a population of over three million shall be eligible for a county facility outpatient adjustment payment. This adjustment payment shall be in addition to the amounts calculated under this Section and are calculated as follows:
    - i) Beginning with July 1, 1995, hospitals under this subsection shall receive an annual adjustment payment equal to total base year hospital outpatient costs trended

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forward to the rate year minus total estimated rate year hospital outpatient payments, multiplied by the resulting ratio derived when the value 200 is divided by the quotient of the difference between total base year hospital outpatient costs trended forward to the rate year and total estimated rate year hospital outpatient payments divided by one million.

- ii) The payment calculated under this subsection (b)(5)(A) may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.
  - iii) The county facility outpatient adjustment under this subsection shall be made on a quarterly basis.
- B) County Facility Outpatient Adjustment Definition. The definitions of terms used with reference to calculation of the county facility outpatient adjustment are as follows:
- i) "Base Year" means the most recently completed State fiscal year.
  - ii) "Rate Year" means the State fiscal year during which the county facility adjustment payments are made.
  - iii) "Total Estimated Rate Year Hospital Outpatient Payments" means the Department's total estimated outpatient date of service liability, projected for the upcoming rate year.
  - iv) "Total Hospital Outpatient Costs" means the statewide sum of all hospital outpatient costs derived by summing each hospital's outpatient charges derived from actual paid claims data multiplied by the hospital's cost-to-charge ratio.
- 6) Critical Access Hospital Rate Adjustment  
Hospitals designated by the Illinois Department of Public Health as Critical Access Hospital (CAH) providers in accordance with 42 CFR 485.subpart F shall be eligible for an outpatient rate adjustment for

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services identified in subsections (b)(1)(A) through (b)(1)(F), excluding services for Medicare/Medicaid crossover claims. This adjustment shall be calculated as follows:

- A) An annual distribution factor shall be calculated as follows:
- i) The numerator shall be \$33 million.
  - ii) The denominator shall be the RY 2011 total outpatient cost coverage deficit calculated in accordance with 89 Ill. Adm. Code 148.115, less the RY 2011 Rural Adjustment Outpatient Payments calculated in accordance with 89 Ill. Adm. Code 148.115, plus the annual outpatient supplemental payment calculated in accordance with 89 Ill. Adm. Code 148.456.
- B) Hospital Specific Adjustment Value  
For each hospital qualified under this subsection (b)(6) the hospital specific adjustment value shall be the product of each hospital's specific cost coverage deficit calculated in subsection (b)(6)(A)(ii) and the distribution factor calculated in subsection (b)(6)(A):
- C) Effective for dates of service on or after July 1, 2012, the final Final APL Rate Adjustment Values shall be the quotient of:
- i) The hospital specific adjustment value identified in subsection (b)(6)(B) divided by
  - ii) The total outpatient services identified in subsections (b)(1)(A) through (b)(1)(~~E~~)(~~F~~), excluding services for Medicare/Medicaid crossover claims for calendar year 2009, adjudicated and contained in the Department's paid claims database as of December 31, 2010.
- D) Non-State Government Owned Provider Adjustment  
Final APL rates for hospitals identified in non-State government owned or operated providers in the State's Upper Payment Limits demonstration shall be adjusted when necessary to assure compliance with federal upper payment limits as stated in 42 CFR

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447.304.

## E) Applicability

The rates calculated in accordance with subsection (b)(6)(A) shall be effective for dates of service beginning January 1, 2011 and shall be adjusted each State fiscal year beginning July 1, 2011.

- i) For State fiscal year 2011, the rate year shall begin January 1, 2011 and end June 30, 2011.
- ii) For State fiscal year 2012 and beyond, the rate year shall be for dates of services beginning July 1 through June 30 of the subsequent year.
- iii) For purposes of this adjustment, a children's hospital identified in Section 149.50(c)(3)(B) shall be combined with the corresponding general acute care parent hospital.
- iv) Beginning with State fiscal year 2012 and each subsequent State fiscal year thereafter, the adjustment to the FY 2011 final APL Rate adjustment shall be limited to 2% in accordance with spending limits in 35 ILCS 5/201.5.

## 7) No Year-End Reconciliation

With the exception of the retrospective rate adjustment described in subsection (b)(9) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).

## 8) Rate Adjustments

With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(5) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

- A) The reimbursement rates described in subsection (b)(5) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the

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two most recent annual Medicaid cost reports.

- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 9) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals reimbursed under the Ambulatory Care Program in the same manner as to encounter rate hospitals and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.
- 10) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- c) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:
- 1) For inpatient hospital services provided pursuant to Section 148.40(c)(1), the Department shall reimburse hospitals pursuant to Sections 148.240 through 148.300 and 89 Ill. Adm. Code 149.
  - 2) For outpatient services or home dialysis treatments provided pursuant to Section 148.40(c)(2) or (c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate that will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2163 (1994). This rate will be that rate established by Medicare pursuant to 42 CFR 405.2124 and 413.170 (1994).
  - 3) Payment for non-routine services. For services that are provided during outpatient or home dialysis treatment pursuant to Section 148.40(c)(2) or (c)(3) but are not defined as a routine service under 42 CFR 405.2163 (1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code

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140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.

- 4) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.
  - 5) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
    - A) The reimbursement rates described in this subsection (c) shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
    - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
  - 6) With the exception of the retrospective rate adjustment described in subsection (c)(5) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (c).
  - 7) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) of this Section shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- d) Non Hospital-Based Clinic Reimbursement
- 1) County-Operated Outpatient Facility Reimbursement  
Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C), that do not qualify as either a Maternal and Child Health Program managed care clinics, as described in 89 Ill. Adm. Code 140.461(f), or as a Critical Clinic Provider, as described in subsection (e) of this Section, shall be on an all-inclusive per encounter rate basis as follows:

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- A) Base Rate. The per encounter base rate shall be calculated as follows:
- i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.
  - ii) The resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section, shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.
  - iii) The resulting product, as calculated in subsection (d)(1)(A)(ii) of this Section, shall be added to the resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section to determine the per encounter base rate.
  - iv) The resulting sum, as calculated in subsection (d)(1)(A)(iii) of this Section, shall be the per encounter base rate.
- B) Supplemental Rate
- i) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.
  - ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.
  - iii) The quotient derived in subsection (d)(1)(B)(i) of this Section shall be added to the product derived in subsection (d)(1)(B)(ii) of this Section, to determine the per encounter supplemental rate.
  - iv) The resulting sum, as described in subsection (d)(1)(B)(iii) of this Section, shall be the per encounter supplemental rate.

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- C) Final Rate
- i) The per encounter base rate, as described in subsection (d)(1)(A)(iv) of this Section, shall be added to the per encounter supplemental rate, as described in subsection (d)(1)(B)(iv) of this Section, to determine the per encounter final rate.
  - ii) The resulting sum, as determined in subsection (d)(1)(C)(i) of this Section, shall be the per encounter final rate.
  - iii) The per encounter final rate, as described in subsection (d)(1)(C)(ii) of this Section, shall be adjusted in accordance with subsection (d)(2) of this Section.
- 2) Rate Adjustments
- Rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) of this Section, shall be calculated as follows:
- A) The reimbursement rates described in subsections (d)(1)(A) through (d)(1)(C) and (e)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
  - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
  - C) The final rate described in subsection (d)(1)(C) of this Section shall be no less than \$147.09 per encounter.
- 3) County-operated outpatient facilities, as described in Section 148.25(b)(2)(C), shall be required to submit outpatient cost reports to the

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Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (d).

- 4) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals reimbursed under the Ambulatory Care Program and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.
- e) Critical Clinic Providers
- 1) Effective for services provided on or after September 27, 1997, a clinic owned or operated by a county with a population of over three million, that is within or adjacent to a hospital, shall qualify as a Critical Clinic Provider if the facility meets the efficiency standards established by the Department. The Department's efficiency standards under this subsection (e) require that the quotient of total encounters per facility fiscal year for the Critical Clinic Provider divided by total full time equivalent physicians providing services at the Critical Clinic Provider shall be greater than:
    - A) 2700 for reimbursement provided during the facility's cost reporting year ending during 1998,
    - B) 2900 for reimbursement provided during the facility's cost reporting year ending during 1999,
    - C) 3100 for reimbursement provided during the facility's cost reporting year ending during 2000,
    - D) 3600 for reimbursement provided during the facility's cost reporting year ending during 2001, and
    - E) 4200 for reimbursement provided during the facility's cost reporting year ending during 2002.

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- 2) Reimbursement for all services provided by any Critical Clinic Provider shall be on an all-inclusive per-encounter rate that shall equal reported direct costs of Critical Clinic Providers for each facility's cost reporting period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.
- 3) Critical Clinic Providers, as described in this subsection (e), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (e).
- 4) The reimbursement rates described in this subsection (e) shall be no less than the reimbursement rates in effect on July 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- f) Critical Clinic Provider Pharmacies  
Prescribed drugs, dispensed by a pharmacy that is a Critical Clinic Provider, that are not part of an encounter reimbursable under subsection (e) of this Section shall be reimbursed at the rate described in subsection (e)(2) of this Section.

(Source: Amended at 37 Ill. Reg. 10432, effective June 27, 2013)

**Section 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements**

- a) Utilization Review  
The Department, or its designated peer review organization, shall conduct utilization review in compliance with Section 1152 of the Social Security Act and 42 CFR Subchapter F (October 1, 2001). A peer review shall be conducted by a Physician Peer Reviewer who is licensed to practice medicine in all its branches, engaged in the active practice of medicine, board certified or board eligible in his or her specialty and has admitting privileges in one or more Illinois hospitals.

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Payment will only be made for those admissions and days approved by the Department or its designated peer review organization. Utilization review may consist of, but not be limited to, preadmission, concurrent, prepayment, and postpayment reviews to determine, pursuant to 42 CFR 476, Subpart C (October 1, 2001), the following:

- 1) Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury;
  - 2) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges, including, but not limited to, the coordination of care requirements defined in Section 148.40(a)(10) for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program;
  - 3) Through DRG (Diagnosis Related Grouping) (see 89 Ill. Adm. Code 149) validation, the validity of diagnostic and procedural information supplied by the hospital;
  - 4) The completeness, adequacy and quality of hospital care provided;
  - 5) Whether the quality of the services meets professionally recognized standards of health care; or
  - 6) Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type.
- b) Notice of Utilization Review
- The Department shall provide hospitals with notice 30 days before a service is subject to utilization review, as described in subsections (c), (d), (e) and (f) of this Section, that the service is subject to such review. In determining whether a particular service is subject to utilization review, the Department may consider factors that include:
- 1) Assessment of appropriate level of care;
  - 2) The service could be furnished more economically on an outpatient basis;

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- 3) The inpatient hospital stays for the service deviate from the norm for inpatient stays using accepted length of stay criteria;
  - 4) The cost of care for the service;
  - 5) Denial rates; and
  - 6) Trends or patterns that indicate potential for abuse.
- c) **Preadmission Review**  
Preadmission review may be conducted prior to admission to a hospital to determine if the services are appropriate for an inpatient setting. The Department shall provide hospitals with notice of the criteria used to determine medical necessity in preadmission reviews 30 days before a service is subject to preadmission review.
- d) **Concurrent Review**  
Concurrent review consists of a certification of admission and, if applicable, a continued stay review.
- 1) The certification of admission is performed to determine the medical necessity of the admission and to assign an initial length of stay based on the criteria for the admission. Admissions will be denied for patients age 21 years of age or over who present at a hospital within 60 days after a previous admission for specified alcohol-induced or drug-induced detoxification. The Department will specify to hospitals the lists of affected diagnosis codes via provider releases and postings on the Department's website.
  - 2) The continued stay review is conducted to determine the medical necessity and appropriateness of continuing the inpatient hospitalization. More than one continued stay review can be performed in an inpatient stay.
- e) **Prepayment Review**  
The Department may require hospitals to submit claims to the Department for prepayment review and approval prior to rendering payment for services provided.

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- f) **Postpayment Review**  
Postpayment review shall be conducted on a random sample of hospital stays following reimbursement to the hospital for the care provided. The Department may also conduct postpayment review on specific types of care.
- g) **Hospital Utilization Control**  
Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456 (October 1, 2001). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1) shall be in accordance with the federal regulations.
- h) **Denial of Payment as a Result of Utilization Review**
- 1) If the Department determines, as a result of utilization review, that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:
    - A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission, transfer of an individual or failure to comply with the coordination of care requirements of Section 148.40.
    - B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.
  - 2) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization, under subsection (h)(1)(A) of this Section as a result of prepayment review, a reconsideration will be provided within 30 days upon the request

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of a hospital or physician if such request is the result of a medical necessity or appropriateness of care denial determination and is received within 60 days after receipt of the notice of denial. The date of the notice of denial is counted as day one.

- 3) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization under subsection (h)(1)(A) of this Section as a result of a preadmission or concurrent review, the hospital or physician may request an expedited reconsideration. The request for expedited reconsideration must include all the information, including the medical record, needed for the Department or its designated peer review organization to make its determination. A determination on an expedited reconsideration request shall be completed within one business day after the Department's or its designated peer review organization's receipt of the request. Failure of the hospital or physician to submit all needed information shall toll the time in which the reconsideration shall be completed. The results of the expedited reconsideration shall be communicated to the hospital by telephone within one business day and in writing within three business days after the determination.
- 4) A determination under subsection (h)(1) of this Section, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in:
  - A) withholding Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
  - B) termination of the hospital's Provider Agreement.
- i) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements
  - 1) The applicable payments made under Sections 148.82, 148.120, 148.130, 148.150, 148.160, 148.170, 148.175 and 148.250 through 148.300 are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (i)(1)(B)(i) through (i)(1)(B)(v) of this Section .

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- A) Hospital-based physicians who may not bill separately on a fee-for-service basis:
- i) A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.
  - ii) A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.
- B) Hospital-based physicians who may bill separately on a fee-for-service basis:
- i) A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.
  - ii) A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.
  - iii) A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.
  - iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.
  - v) A physician holding a nonteaching administrative or staff

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position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

- 2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.
- j) "Designated peer review organization" means an organization designated by the Department that is experienced in utilization review and quality assurance, which meets the guidelines in Section 1152 of the Social Security Act and 42 CFR 475 (October 1, 2001).

(Source: Amended at 37 Ill. Reg. 10432, effective June 27, 2013)

**Section 148.285 Excellence in Academic Medicine Payments (Repealed)**

~~Payments for Qualified Academic Medical Center Hospitals providing graduate medical education shall be made for inpatient admissions occurring on or after July 1, 1996, and for Independent Academic Medical Center Hospitals providing graduate medical education shall be made for inpatient admissions occurring on or after July 1, 2001, as follows:~~

- a) ~~Subject to the availability of funds from the accounts within the Medical Research and Development Fund, including any federal financial participation reimbursed for payments under this subsection (a), payments shall be made to hospitals under the following criteria:~~
  - 1) ~~Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive a percentage of the amount available from the National Institutes of Health Account, equal to that hospital's percentage of the total contracts and grants from the National Institutes of Health awarded to Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospitals and their affiliated medical schools during the preceding calendar year as reported to the Department.~~

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- ~~2) Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive payment from the Philanthropic Medical Research Account equal to 25 percent of all funded grants (other than grants funded by the State of Illinois or the National Institutes of Health) for biomedical research, technology, or programmatic development received by the Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital during the preceding calendar year as reported to the Department.~~
- ~~3) Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive payment from the Market Medical Research Account equal to 20 percent of the funding for the project, if, based upon submission of information to the Department, the hospital:
  - ~~A) contributes 40 percent of the funding, that is at least \$100,000, for a biomedical research or technology project or a programmatic development project, and~~
  - ~~B) obtains contributions from the private sector equal to 40 percent of the funding for the project.~~~~
- ~~b) No hospital receiving payments from the Medical Research and Development Fund shall receive more than 20 percent of the total amount appropriated to the Fund, except that total payments from the Fund to the primary teaching hospitals affiliated with the Southern Illinois University School of Medicine in Springfield, considered as a single entity, may not exceed the product of:
  - ~~1) One-sixth of the total amount available for distribution from the Medical Research and Development Fund, and~~
  - ~~2) The quotient of the National Institutes of Health grants or contracts awarded to the Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals in the previous calendar year divided by \$8,000,000.~~~~
- ~~e) The Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals located in Springfield, considered as a single entity, shall be deemed to be a Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital for the purposes of calculating subsections (a)~~

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~~and (b) of this Section. Payments under subsections (a) and (b) of this Section made to the Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals located in Springfield shall be made to, and divided equally between, the primary teaching hospitals in Springfield.~~

- ~~d) Subject to the availability of funds from the Post-Tertiary Clinical Services Fund, including any federal financial participation reimbursed for payments under this subsection (d), payments shall be made to Qualified Academic Medical Center Hospitals for up to three Qualified Programs in any given year as reported to the Department. Qualified Academic Medical Center Hospitals may receive continued funding for previously funded Qualified Programs rather than receive funding for a new program so long as the number of Qualified Programs receiving funding does not exceed three. Each hospital receiving payments under this subsection (d) shall receive an equal percentage of the Post-Tertiary Clinical Services Fund to be used in the funding of Qualified Programs.~~
- ~~e) Subject to the availability of funds from the Independent Academic Medical Center Fund, including any federal financial participation reimbursed for payments under this subsection (e), payments shall be made to Independent Academic Medical Center Hospitals.~~
- ~~f) Payments from funds under this Section are made to cover the direct costs associated with providing Medicaid services and shall be made directly to the Qualified Academic Medical Center Hospitals or Independent Academic Medical Center Hospitals due the funds, except any funds due to any primary teaching hospital for the University of Illinois School of Medicine at Rockford and the University of Illinois School of Medicine at Peoria shall be paid to the University of Illinois at Chicago Medical Center, which shall be bound to expend the funds on its affiliated hospitals due the funds.~~
- ~~g) No Academic Medical Center Hospital shall be eligible for payments from the Medical Research and Development Fund unless the Academic Medical Center Hospital, in connection with its affiliated medical school, received at least \$8,000,000 in the preceding calendar year in grants or contracts from the National Institutes of Health, except that this restriction does not apply to the entity specified in subsection (e) of this Section.~~
- ~~h) The rate period for payments made under this Section shall be the 12-month period beginning July 1, 1996, for Qualified Academic Medical Center Hospitals;~~

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~~and July 1, 2001, for Independent Academic Medical Center Hospitals. A qualifying hospital's total annual payments from each fund and account described in this Section shall be divided into four equal payments and be made by the later of:~~

- ~~1) the fifteenth working day after July 1, October 1, January 1, and March 1, or~~
  - ~~2) the fifteenth working day after the Department's receipt of reporting information required under subsection (j) of this Section.~~
- ~~i) Payments made under this Section are for inpatient Medicaid services provided in the 12 month period preceding the rate period.~~
  - ~~j) Qualified Academic Medical Center Hospitals initially identified by the Department as qualifying under any payment criteria of this Section must complete and return a survey, developed by the Department, attesting to information required to calculate payments under this Section. The Department will mail the survey at least 21 days prior to its due date. Failure to complete and submit required information by the due dates established by the Department will result in forfeiture of payments under this Section.~~
  - ~~k) If a hospital is eligible for funds from the Independent Academic Medical Center Fund, that hospital shall not receive funds from the Medical Research and Development Fund or the Post-Tertiary Clinical Services Fund. If a hospital receives funds from the Medical Research and Development Fund or the Post-Tertiary Clinical Services Fund, that hospital is ineligible to receive funds from the Independent Academic Medical Center Fund.~~
  - ~~l) Definitions  
As used in this Section, unless the context requires otherwise:~~
    - ~~1) "Academic Medical Center Hospital" means a hospital located in Illinois which is either under common ownership with the college of medicine of a college or university, or a free-standing hospital in which the majority of the clinical chiefs of service are department chairmen in an affiliated medical school.~~
    - ~~2) "Academic Medical Center Children's Hospital" means a children's~~

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~~hospital which is separately incorporated and non-integrated into the Academic Medical Center Hospital, but which is the pediatric partner for an Academic Medical Center Hospital and serves as the primary teaching hospital for pediatrics for its affiliated medical school. Children's hospitals which are separately incorporated, but integrated into the Academic Medical Center Hospital, are considered part of the Academic Medical Center Hospital.~~

- 3) ~~"Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means an Academic Medical Center Hospital located in the Chicago Metropolitan Statistical Area.~~
- 4) ~~"Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means an Academic Medical Center Hospital located outside the Chicago Metropolitan Statistical Area.~~
- 5) ~~"Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means any Chicago Metropolitan Statistical Area Academic Medical Center Hospital that either directly or in connection with its affiliated medical school receives in excess of \$8,000,000 in grants or contracts from the National Institutes of Health during the calendar year preceding the beginning of the State fiscal year, except for the purposes of subsection (c) of this Section.~~
- 6) ~~"Qualified Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means the primary teaching hospital of the University of Illinois School of Medicine at Peoria, the primary teaching hospital for the University of Illinois School of Medicine at Rockford and the primary teaching hospitals for Southern Illinois University School of Medicine in Springfield.~~
- 7) ~~"Qualified Academic Medical Center Hospital" means a Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital, a Qualified Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital or an Academic Medical Center Children's Hospital.~~
- 8) ~~"Independent Academic Medical Center Hospital" means the primary teaching hospital for the University of Illinois College of Medicine that is located in Urbana.~~

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- 9) ~~"Qualified Program" includes:~~
- A) ~~Thoracic transplantation: heart and lung, in particular,~~
  - B) ~~Cancer: particularly biologic modifiers of tumor response, and mechanisms of drug resistance in cancer therapy,~~
  - C) ~~Shock/Burn: development of biological alternatives to skin for grafting in burn injury, and research in mechanisms of shock and tissue injury in severe injury,~~
  - D) ~~Abdominal transplantation: kidney, liver, pancreas, and development of islet cell and small bowel transplantation technologies,~~
  - E) ~~Minimally invasive surgery: particularly laparoscopic surgery,~~
  - F) ~~High performance medical computing: telemedicine and teleradiology,~~
  - G) ~~Transmyocardial laser revascularization: a laser creates holes in heart muscles to allow new blood flow,~~
  - H) ~~PET scanning: viewing how organs function (CT and MRI only allow viewing of the structure of an organ),~~
  - I) ~~Strokes in the African-American community: particularly risk factors for cerebral vascular accident (strokes) in the African-American community at much higher risk than the general population,~~
  - J) ~~Neurosurgery: particularly focusing on interventional neuroradiology,~~
  - K) ~~Comprehensive eye center: including further development in pediatric eye trauma,~~
  - L) ~~Cancers: particularly melanoma, head and neck,~~

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- ~~M) Pediatric cancer;~~
- ~~N) Invasive pediatric cardiology;~~
- ~~O) Pediatric organ transplantation: transplantation of solid organs and marrow and other stem cells, and~~
- ~~P) Such other programs as may be identified by the Department and the Qualified Academic Medical Center Hospital, and approved by the Department, for those programs that meet appropriate biomedical research, technology, or programmatic development standards. Programs that meet appropriate biomedical research, technology or programmatic development standards are those programs that help prevent, detect, diagnose, and treat disease and disability in humans by conducting research that seeks to produce new knowledge, developing or refining medical technologies, or creating, strengthening or expanding the clinical programs of academic medical centers. Moreover, such programs meet the purpose of the Excellence in Academic Medicine Act [30 ILCS 775/5]. That is, they stimulate excellence in academic medicine in Illinois for this and future generations, elevate Illinois as a national center for academic medicine and for health care innovation in the United States, and reverse the current health care trade imbalance so Illinois citizens may obtain highest quality post-tertiary care at home in Illinois.~~

(Source: Repealed at 37 Ill. Reg. 10432, effective June 27, 2013)

**Section 148.295 Critical Hospital Adjustment Payments (CHAP)**

Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), unless otherwise noted in this Section, and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for inpatient admissions occurring on or after July 1, 1998, in accordance with this Section. For a hospital that is located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 no new payment or rate increase that would otherwise become effective for dates of

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service on or after July 1, 2010 shall take effect under this Section unless the qualifying hospital also meets the definition of a Coordinated Care Participating Hospital as defined in subsection (g)(5) of this Section no later than six months after the effective date of the first mandatory enrollment in the Coordinated Care Program.

- a) Trauma Center Adjustments (TCA)

The Department shall make a TCA to hospitals recognized, as of the first day of July in the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health (DPH) in accordance with the provisions of subsections (a)(1) through (a)(4) of this Section. For the purpose of a TCA, a children's hospital, as defined under 89 Ill. Adm. Code 149.50(c)(3), operating under the same license as a hospital designated as a trauma center, shall be deemed to be a trauma center.

  - 1) Level I Trauma Center Adjustment.
    - A) Criteria. Hospitals that, on the first day of July in the CHAP rate period, are recognized as a Level I trauma center by DPH shall receive the Level I trauma center adjustment. Hospitals qualifying under subsection (a)(2) are not eligible for payment under this subsection.
    - B) Adjustment. Hospitals meeting the criteria specified in subsection (a)(1)(A) of this Section shall receive an adjustment as follows:
      - i) Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of \$21,365 per Medicaid trauma admission in the CHAP base period.
      - ii) Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of \$14,165 per Medicaid trauma admission in the CHAP base period.
  - 2) Level I Trauma Center Adjustment for hospitals located in the same city that alternate their Level I trauma center designation.

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- A) Criteria. Hospitals that are located in the same city and participate in an agreement in effect as of July 1, 2007, whereby their designation as a Level I trauma center by the Illinois Department of Public Health is rotated among qualifying hospitals from year to year or during a year, that are in the following classes:
- i) A children's hospital – All children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3), in a given city, qualifying under subsection (a)(2)(A) shall be considered one entity for the purpose of calculating the adjustment in subsection (a)(2)(B).
  - ii) A general acute care hospital – All general acute care adult hospitals, in a given city, affiliated with a children's hospital, as defined in subsection (a)(2)(A)(i), qualifying under subsection (a)(2)(A) shall be considered one entity for the purposes of calculating the adjustment in subsection (a)(2)(B).
- B) Adjustment. Hospitals meeting the criteria specified in subsection (a)(2)(A) shall receive an adjustment as follows:
- i) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is equal to or greater than the mean Medicaid trauma admissions for the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of \$5,250 per Medicaid trauma admission for that class, in the CHAP base period.
  - ii) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is less than the mean Medicaid trauma admissions of the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of \$3,625 per Medicaid trauma admission for that class in the CHAP base period.

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- 3) Level II Rural Trauma Center Adjustment. Rural hospitals, as defined in Section 148.25(g)(3), that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of \$11,565 per Medicaid trauma admission in the CHAP base period.
  - 4) Level II Urban Trauma Center Adjustment. Urban hospitals, as described in Section 148.25(g)(4), that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of \$11,565 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the criteria described below:
    - A) The hospital is located in a county with no Level I trauma center; and
    - B) The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the first day of July in the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(4) of this Section; or the hospital is not located in an HPSA and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(4) of this Section; and
    - C) The hospital does not qualify under subsection (a)(2).
  - 5) In determining annual payments that are pursuant to the Trauma Center Adjustments as described in this Section, for the CHAP rate period occurring in State fiscal year 2009, total payments will equal the methodologies described in this Section. For the period December 1, 2008 to June 30, 2009, payment will equal the State fiscal year 2009 amount less the amount the hospital received for the period July 1, 2008 to November 30, 2008.
- b) Rehabilitation Hospital Adjustment (RHA)  
Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as free-standing acute comprehensive rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), and that are accredited by the Commission on

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Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission (previously known as the Joint Committee on Accreditation of Healthcare Organizations), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following four components:

- 1) Treatment Component. All hospitals defined in subsection (b) of this Section shall receive \$4,215 per Medicaid Level I rehabilitation admission in the CHAP base period.
  - 2) Facility Component. All hospitals defined in subsection (b) of this Section shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:
    - A) Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of \$229,360 in the CHAP rate period.
    - B) Hospitals with 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of \$527,528 in the CHAP rate period.
  - 3) Health Professional Shortage Area Adjustment Component. Hospitals defined in subsection (b) of this Section that are located in an HPSA on July 1, 1999, shall receive \$276.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.
  - 4) Hospitals qualifying under this subsection (b) that are, as of July 1, 2010, designated as a "magnet hospital" by the American Nurses' Credentialing Center will receive a magnet component of \$1,500,000 annually for the period July 1, 2010 ~~through June 30, 2012.~~ through December 31, 2014
- c) Direct Hospital Adjustment (DHA) Criteria
- 1) Qualifying Criteria  
Hospitals may qualify for the DHA under this subsection (c) under the following categories unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency

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treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006:

- A) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:
  - i) were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999 and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;
  - ii) were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999 and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or
  - iii) were county owned hospitals as defined in 89 Ill. Adm. Code 148.25(b)(1)(A), and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.
- B) Illinois hospitals located outside of HSA 6 that had an MIUR greater than 60 percent on July 1, 1999 and an average length of stay less than ten days. The following hospitals are excluded from qualifying under this subsection (c)(1)(B): children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.
- C) Children's hospitals, as defined under 89 Ill. Adm. Code 149.50(c)(3), on July 1, 1999.
- D) Illinois teaching hospitals, with more than 40 graduate medical education programs on July 1, 1999, not qualifying in subsection (c)(1)(A), (B), or (C) of this Section.
- E) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsection

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(c)(1)(A), (B), (C) or (D) of this Section, all other hospitals located in Illinois that had an MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999 and provided more than 15,000 total days.

- F) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A), (B), (C), (D), or (E) of this Section, all other hospitals that had an MIUR greater than 40 percent on July 1, 1999 and provided more than 7,500 total days and provided obstetrical care as of July 1, 2001.
- G) Illinois teaching hospitals with 25 or more graduate medical education programs on July 1, 1999 that are affiliated with a Regional Alzheimer's Disease Assistance Center as designated by the Alzheimer's Disease Assistance Act [410 ILCS 405/4], that had an MIUR less than 25 percent on July 1, 1999 and provided 75 or more Alzheimer days for patients diagnosed as having the disease.
- H) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(G) of this Section, all other hospitals that had an MIUR greater than 50 percent on July 1, 1999.
- I) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(H) of this Section, all other hospitals that had an MIUR greater than 23 percent on July 1, 1999, had an average length of stay less than four days, provided more than 4,200 total days and provided 100 or more Alzheimer days for patients diagnosed as having the disease.
- J) A hospital that does not qualify under subsection (c)(1) of this Section because it does not operate a comprehensive emergency room will qualify if the hospital provider operates a standby

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emergency room, as defined in 77 Ill. Adm. Code 250.710(c), and functions as an overflow emergency room for its affiliate hospital provider, owned and controlled by the same governing body, that operates a comprehensive emergency room, as defined in 77 Ill. Adm. Code 250.710(a), within one mile of the hospital provider.

- 2) DHA Rates
  - A) For hospitals qualifying under subsection (c)(1)(A) of this Section, the DHA rates are as follows:
    - i) Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive \$69.00 per day for hospitals that do not provide obstetrical care and \$105.00 per day for hospitals that do provide obstetrical care.
    - ii) Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will receive \$105.00 per day for hospitals that do not provide obstetrical care and \$142.00 per day for hospitals that do provide obstetrical care.
    - iii) Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviation above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive \$124.00 per day for hospitals that do not provide obstetrical care and \$160.00 per day for hospitals that do provide obstetrical care.
    - iv) Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive \$142.00 per day for hospitals that do not provide obstetrical care and \$179.00 per day for hospitals that do provide obstetrical care.

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- B) Hospitals qualifying under subsection (c)(1)(A) of this Section will also receive the following rates:
- i) County owned hospitals as defined in Section 148.25 with more than 30,000 total days will have their rate increased by \$455.00 per day.
  - ii) Hospitals that are not county owned with more than 30,000 total days will have their rate increased by \$354.00 per day for dates of service on or after April 1, 2009.
  - iii) Hospitals with more than 80,000 total days will have their rate increased by an additional \$423.00 per day.
  - iv) Hospitals with more than 4,500 obstetrical days will have their rate increased by \$101.00 per day.
  - v) Hospitals with more than 5,500 obstetrical days will have their rate increased by an additional \$194.00 per day.
  - vi) Hospitals with an MIUR greater than 74 percent will have their rate increased by \$147.00 per day.
  - vii) Hospitals with an average length of stay less than 3.9 days will have their rate increased by \$385.00 per day through ~~December 31, 2014~~ ~~June 30, 2012~~. For dates of service on or after ~~January 1, 2015~~ ~~July 1, 2012~~, the rate is \$131.00.
  - viii) Hospitals with an MIUR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999 will have their rate increased by \$360.00 per day for dates of service on or after April 1, 2009.
  - ix) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an average length of stay less than

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four days will have their rate increased by \$650.00 per day for dates of service on or after April 1, 2009.

- x) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an MIUR greater than 60 percent will have their rate increased by \$320.50 per day.
  - xi) Hospitals receiving payments under subsection (c)(2)(A)(iv) of this Section that have an MIUR greater than 70 percent and have more than 20,000 days will have their rate increased by \$185.00 per day for dates of service on or after April 1, 2009.
  - xii) Hospitals with a Combined MIUR greater than 75 percent that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate increased by \$148.00 per day.
- C) Hospitals qualifying under subsection (c)(1)(B) of this Section will receive the following rates:
- i) Qualifying hospitals will receive a rate of \$421.00 per day.
  - ii) Qualifying hospitals with more than 1,500 obstetrical days will have their rate increased by \$824.00 per day through ~~December 31, 2014~~June 30, 2012. For dates of service on or after ~~January 1, 2015~~July 1, 2012, the rate is \$369.00.
- D) Hospitals qualifying under subsection (c)(1)(C) of this Section will receive the following rates:
- i) Hospitals will receive a rate of \$28.00 per day.
  - ii) Hospitals located in Illinois and outside of HSA 6 that have an MIUR greater than 60 percent will have their rate increased by \$55.00 per day.

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- iii) Hospitals located in Illinois and inside HSA 6 that have an MIUR greater than 80 percent will have their rate increased by \$573.00 per day. For dates of service on or after July 1, 2010 through ~~December 31, 2014~~June 30, 2012, this rate shall be increased by an additional \$47.00, to \$620.00.
- iv) Hospitals that are not located in Illinois that have an MIUR greater than 45 percent will have their rate increased by:
- For hospitals that have fewer than 4,000 total days, \$32.00 per day.
  - For hospitals that have more than 4,000 total days but fewer than 8,000 total days, \$363.00 per day for dates of service through ~~December 1, 2014~~June 30, 2012; for dates of service on or after ~~January 1, 2015~~July 1, 2012, the rate is \$246.00 per day.
  - For hospitals that have more than 8,000 total days, \$295.00 per day for dates of service through ~~December 31, 2014~~June 30, 2012; for dates of service on or after ~~January 1, 2015~~July 1, 2012, the rate is \$178 per day.
- v) Hospitals with more than 3,200 total admissions will have their rate increased by \$328.00 per day.
- E) Hospitals qualifying under subsection (c)(1)(D) of this Section will receive the following rates:
- i) Hospitals will receive a rate of \$41.00 per day.
  - ii) Hospitals with an MIUR between 18 percent and 19.75 percent will have their rate increased by an additional \$14.00 per day.
  - iii) Hospitals with an MIUR equal to or greater than 19.75 percent will have their rate increased by an additional

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\$191.00 per day for dates of service on or after April 1, 2009.

- iv) Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rate increased by an additional \$41.00 per day. For dates of service on or after July 1, 2010 through ~~June 30, 2012~~ December 31, 2014, this rate shall be further increased by \$54.00 per day, to \$95.00 per day.
- F) Hospitals qualifying under subsection (c)(1)(E) of this Section will receive \$188.00 per day.
- G) Hospitals qualifying under subsection (c)(1)(F) of this Section will receive a rate of \$55.00 per day.
- H) Hospitals that qualify under subsection (c)(1)(G) of this Section will receive the following rates:
  - i) Hospitals with an MIUR greater than 19.75 percent will receive a rate of \$69.00 per day.
  - ii) Hospitals with an MIUR equal to or less than 19.75 percent, will receive a rate of \$11.00 per day.
- I) Hospitals qualifying under subsection (c)(1)(H) of this Section will receive a rate of \$268.00 per day.
- J) Hospitals qualifying under subsection (c)(1)(I) of this Section will receive a rate of \$328.00 per day if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$238.00 per day.
- K) Hospitals that qualify under subsection (c)(1)(A)(iii) of this Section will have their rates multiplied by a factor of two. The payments calculated under this Section to hospitals that qualify under subsection (c)(1)(A)(iii) of this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments

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calculated under this Section may be classified as disproportionate share adjustments for hospitals qualifying under subsection (c)(1)(A)(iii) of this Section.

- 3) DHA Payments
  - A) Payments under this subsection (c) will be made at least quarterly, beginning with the quarter ending December 31, 1999.
  - B) Payment rates will be multiplied by the total days.
  - C) For the CHAP rate period occurring in State fiscal year 2011, total payments will equal the methodologies described in subsection (c)(2) of this Section.
- d) Rural Critical Hospital Adjustment Payments (RCHAP)

RCHAP shall be made to rural hospitals, as described in 89 Ill. Adm. Code 140.80(j)(1), for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive \$367,179 per year. The Department shall also make an RCHAP to hospitals qualifying under this subsection at a rate that is the greater of:

  - 1) the product of \$1,367 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or
  - 2) the product of \$138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.
- e) Total CHAP Adjustments

Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in subsections (a), (b), (c) and (d) of this Section. The critical hospital adjustment payments shall be paid at least quarterly.
- f) Critical Hospital Adjustment Limitations

Hospitals that qualify for trauma center adjustments under subsection (a) of this Section shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment

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described in subsection (a)(1) of this Section, or a Level II trauma center as required for the adjustment described in subsection (a)(2) or (a)(3) of this Section. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased. This limitation does not apply to hospitals qualifying under subsection (a)(2). Payments under this Section are subject to federal approval.

## g) Critical Hospital Adjustment Payment Definitions

The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:

- 1) "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates of service occurring in State fiscal year 2001 and adjudicated through June 30, 2002.
- 2) "CHAP base period" means State Fiscal Year 1994 for CHAP calculated for the July 1, 1995 CHAP rate period; State Fiscal Year 1995 for CHAP calculated for the July 1, 1996 CHAP rate period; etc.
- 3) "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.
- 4) "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, and as defined in Section 148.120(k)(5), plus the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120(k)(6), as of July 1, 1999.
- 5) "Coordinated Care Participating Hospital" means a hospital that is located in a ~~county geographic area~~ of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program as defined in 305 ILCS 5/5-30 that is one of the following:
  - A) Has entered into a contract to provide hospital services to enrollees of the care coordination program.
  - B) Has not been offered a contract by a care coordination plan that pays not less than the Department would have paid on a fee-for-

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service basis, but excluding disproportionate share hospital adjustment payments or any other supplement payment that the Department pays directly.

- C) Is not licensed to serve the population mandated to enroll in the care coordination program.
- 6) "Medicaid general care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.
- 7) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.
- 8) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.
- 9) "Medicaid obstetrical care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with Diagnosis Related Grouping (DRG) of 370 through 375; and specifically excludes Medicare/Medicaid crossover claims.

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- 10) "Medicaid trauma admission" means those claims billed as admissions for recipients of medical assistance under Title XIX of the Social Security Act that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.31, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925 through 925.2, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.
- 11) "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all Level II urban trauma centers.
- 12) "RCHAP general care admissions" means Medicaid General Care Admissions, as defined in subsection (g)(4) of this Section, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.
- 13) "RCHAP obstetrical care admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection (g)(7) of this Section, with a Diagnosis Related Grouping (DRG) of 370 through 375, occurring in the CHAP base period.
- 14) "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

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- 15) "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.
- 16) "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5<sup>th</sup> digit of 1 or 2; 650; 651.0 through 659.9 with a 5<sup>th</sup> digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5<sup>th</sup> digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5<sup>th</sup> digit of 1 or 2; V27 through V27.9; V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

(Source: Amended at 37 Ill. Reg. 10432, effective June 27, 2013)

**Section 148.458 General Provisions**

Unless otherwise indicated, the following apply to Sections 148.440 through 148.456.

a) Definitions.

"Base inpatient payments" means, for a given hospital, the sum of payments made using the rates defined in Section 148(b)(1) for services provided during State fiscal year 2005 and adjudicated by the Department through March 23, 2007.

"Capital cost per diem" means, for a given hospital, the quotient of (i) the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, divided by (ii) the total inpatient days from the same cost report to calculate a capital cost per day. The resulting capital cost per day is inflated to the midpoint of State fiscal year 2009 utilizing the national hospital market price proxies hospital cost index. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, the Department shall use the data reported on the hospital's 2005 Medicaid cost report.

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"Case mix index" means, for a given hospital, the quotient resulting from dividing (i) the sum of the all diagnosis related grouping relative weighting factors in effect on January 1, 2005, for all category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82, by (ii) the total number of category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82.

"Children's hospital" means a hospital as described in Section 149.50(c)(3).

"Eligibility growth factor" means the percentage by which the number of Medicaid recipients in the county increased from State fiscal year 1998 to State fiscal year 2005.

"Freestanding children's hospital" means an Illinois Children's hospital that is licensed by the Illinois Department of Public Health as a pediatric hospital.

"Freestanding specialty hospital" means an Illinois hospital that is neither a general acute care hospital nor a large public hospital nor a freestanding children's hospital.

"General acute care hospital" means an Illinois hospital that operates under a general license (i.e., is not licensed by the Illinois Department of Public Health as a psychiatric, pediatric, rehabilitation, or tuberculosis specialty hospital) and is not a long term stay hospital, as described in Section 149.50(c)(4).

"Large public hospital" means a county-owned hospital, as described in Section 148.25(b)(1)(a), a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(b), or a hospital owned or operated by a State agency, as described in Section 148.40(a)(7).

"Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during State fiscal year 2005 as adjudicated by the Department through March 23, 2007.

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"Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to Illinois recipients of medical assistance under Title XIX of the federal Social Security Act, assigned a diagnosis related group code of 370 through 375, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during State fiscal year 2005, adjudicated by the Department through March 23, 2007.

"Medicaid obstetrical rate" means, for a given hospital, a fraction, the numerator of which is the hospital's Medicaid obstetrical days and the denominator is the hospital's Medicaid inpatient days.

"Medicare crossover rate" means, for a given hospital, a fraction, the numerator of which is the number patient days provided to individuals eligible for both Medicare under Title XVIII and Medicaid under Title XIX of the federal Social Security Act and the denominator of which is the number patient days provided to individuals eligible for medical programs administered by the Department, both as recorded in the Department's paid claims data.

"MIUR" means Medicaid inpatient utilization rate as defined in Section 148.120(K)(4).

b) Payment.

- 1) The annual amount of each payment for which a hospital qualifies shall be made in 12 equal installments on or before the seventh State business day of each month. If a hospital closes or ceases to do business, payments will be prorated based on the number of days the hospital was open during the State fiscal year in which the hospital closed or ceased to do business.
- 2) Monthly payments may be combined into a single payment to a qualifying hospital. Such a payment will represent the total monthly payment a qualifying hospital receives pursuant to Sections 148.440 through 148.456.
- 3) The Department may adjust payments made pursuant to Article V-A of the Public Aid Code to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.

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4) If the federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under Article V-A of the Illinois Public Aid Code is exceeded, then the payments under Article V-A of the Illinois Public Aid Code that exceed the applicable federal upper limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

## c) Rate reviews.

- 1) A hospital shall be notified in writing of the results of the payment determination pursuant to Sections 148.440 through 148.456.
- 2) Hospitals shall have a right to appeal the calculation of, or their ineligibility for, payment if the hospital believes that the Department has made a technical error. The appeal must be submitted in writing to the Department and must be received or postmarked within 30 days after the date of the Department's notice to the hospital of its qualification for the payment amounts, or a letter of notification that the hospital does not qualify for payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

(Source: Amended at 37 Ill. Reg. 10432, effective June 27, 2013)

## SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

**Section 148.510 Reimbursement**

When a hospital or ambulance provider furnishes emergency services, a hospital or health care professional or laboratory provides follow-up healthcare, or a pharmacy dispenses prescribed medications to any sexual assault survivor who is neither eligible to receive those services under the Illinois Public Aid Code [305 ILCS 5/5] nor covered for those services by a policy of insurance, the hospital, ambulance provider, health care professional, laboratory or pharmacy shall furnish the services without charge to that person, and shall be entitled to be reimbursed in providing the services, under the following conditions:

- a) An Illinois hospital shall be eligible for reimbursement only after receiving

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Department of Public Health approval for participation as a Sexual Assault Treatment Facility or as a Sexual Assault Transfer Facility.

- b) Charges for outpatient emergency care, physician, and ambulance transportation, and other related charges, shall be reimbursed as described in this subsection ~~(b): only through the hospital outpatient billing department.~~
- 1) Physicians, ambulance providers, and other miscellaneous medical providers rendering services in the hospital emergency department shall ~~not~~ be directly reimbursed by the Department of Healthcare and Family Services.
  - 2) Charges for inpatient care shall not be reimbursed.
  - 3) Charges must be directly related to care rendered for examinations, injuries, or trauma resulting from a sexual assault and/or the completion of sexual assault evidence collection through the use and application of the Illinois State Police Sexual Assault Evidence Collection Kit.
  - 4) Emergency services must have been provided within the hospital emergency department or under the direction of an attending emergency room physician at the facility who supervised or provided the hospital emergency care of the sexual assault survivor, or during the ambulance transport of the sexual assault survivor.
  - 5) Charges may include, but are not limited to, outpatient emergency care, physician, laboratory, x-ray, pharmacy and ambulance services, including charges for follow-up visits to the emergency department that are related to the sexual assault and occur within 90 days after the initial visit.
  - 6) ~~Services~~ ~~The billed charges for services~~ provided to sexual assault survivors shall be reimbursed at the Department's reimbursement rates, no greater than the provider's customary charges to the general public for those types of services. Physician fees shall be no greater than those considered usual and customary in the community. Pharmacy services shall be reimbursed at the Department's pharmacy reimbursement rates established in 89 Ill. Adm. Code 140.445 and 89 Ill. Adm. Code 140.446.
  - 7) Claims must be received by the Department within 180 days ~~12 months~~

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from the date of service to be eligible for payment pursuant to 89 Ill. Adm. Code 140.20.

- c) The hospital shall maintain sufficient records to document its charges for services to each sexual assault survivor. The records shall be available for the Department's review upon its request and shall contain at least the following:
- 1) Sexual assault survivor's name, address, date of birth, Social Security Number, marital status, sex, employer and name of parent or guardian (if minor patient);
  - 2) Date of service;
  - 3) Hospital patient number and name of attending physician;
  - 4) List of services provided;
  - 5) Charges for each service;
  - 6) Any documentation concerning the sexual assault survivor's insurance coverage; and
  - 7) A report outlining each service provided and paid for by the Department and the services available to sexual assault survivors.
- d) The hospital outpatient-billing department shall submit the following documentation in order to be considered for reimbursement:
- ~~1) The Illinois Department of Healthcare and Family Services Sexual Assault Survivor Program Outpatient Hospital Billing Form, completed in its entirety for the initial visit and follow-up visits;~~
  - ~~12) Documentation~~When applicable, the Billing Form with documentation of any insurance payment that has been received, or a copy of the denial from the insurance carrier; and
  - ~~3) A legible copy of the emergency room admission form with physician's notes and orders and nurse's notes; and~~

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24) ~~A properly completed Universal Billing (UB) Form. Itemized statement of all charges from each provider.~~

- e) The health care professional who provides follow-up healthcare, the laboratory that furnishes follow-up services, and the pharmacy that dispenses related prescribed medications to a sexual assault survivor are responsible for submitting the request for reimbursement for follow-up healthcare, laboratory services or pharmacy services to the Illinois Sexual Assault Emergency Treatment Program under the Department of Healthcare and Family Services. Health care professionals, ~~and laboratories~~ and pharmacies are ~~entitled~~ to be reimbursed at the Department's reimbursement rates for their billed charges. ~~Pharmacies shall be reimbursed at the Department's pharmacy reimbursement rates established in 89 Ill. Adm. Code 140.445 and 140.446.~~
- f) Under no circumstances shall a sexual assault survivor be billed for outpatient hospital care, emergency room care, follow-up health care or transportation services when the services are directly related to the sexual assault.
- g) A request for reimbursement that is rejected by the Department shall be returned to the requestor and accompanied by an explanation that specifies the basis for rejection. Corrected or amended requests may be resubmitted to the Department within 180 days~~12 months~~ from the date of service pursuant to 89 Ill. Adm. Code 140.20.

(Source: Amended at 37 Ill. Reg. 10432, effective June 27, 2013)

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- 1) Heading of the Part: Hospital Reimbursement Changes
- 2) Code Citation: 89 Ill. Adm. Code 152
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
152.100	New Section
152.200	Amendment
152.300	New Section
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: February 1, 2013; 37 Ill. Reg. 1102
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: The following changes were made:

In subsection 152.100(c) of Section 152.100, capitalize "state".

In subsection 152.300(c) of Section 152.300, change "shall be defined as follows" to "are defined in this subsection (c). The definitions manual applicable to the PPR software created and maintained by the 3M Corporation that HFS will use to process admissions data and determine whether an admission is a Potentially Preventable Readmission can be accessed at [www.aprdrgassign.com](http://www.aprdrgassign.com)."

In subsection 152.300(c) of Section 152.300 added the definition:

"4) Clinically Related" shall mean that the underlying reason for readmission is plausibly related to the care rendered during a prior hospital admission. A clinically-related readmission results from the process of care and treatment

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provided during the prior admission (e.g., readmission for a surgical wound infection) or from a lack of post-admission follow up (e.g., lack of follow-up care arrangements with a primary physician) rather than from unrelated events that occurred after the prior admission (such as a broken leg due to trauma) within a specified readmission time interval."

In subsection 152.300(c)(4) of Section 152.300, change "has" to "is followed by a".

In subsection 152.300(c) of Section 152.300, change the subsection labels from "(4)" through "(11)" to "(5)" through "(12)".

In subsection 152.300(c)(4) of Section 152.300, in the definition "Initial Admission" change "in" to "or readmissions within" and "is clinically related based on" to "are determined by" and after "methodology" add "to be clinically related".

In subsection 152.300(d)(2)(B) of Section 152.300, after "or" add a comma and after "(4)" add a comma.

In subsection 152.300(e)(2) of Section 152.300, change "The" to "Except as otherwise provided in subsection (f)(8), the".

In subsection 152.300(f)(4) of Section 152.300, change "ratio" to "arithmetic operation" and after "(3)" add a comma.

In subsection 152.300(f) of Section 152.300, add an "8)" to read:

"8) After the Department verifies that all hospitals have achieved \$40 million savings in aggregate for fiscal year 2013 when compared to the base year, no further payment reductions will be applied to individual hospitals."

- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? Yes, July 13, 2012; 36 Ill. Reg. 10410 and January 2, 2013; 37 Ill. Reg. 282
- 14) Are there any other proposed rulemakings pending on this Part? No

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- 15) Summary and Purpose of Rulemaking: These administrative rules are authorized by PA 97-689, also referred to as the Saving Medicaid Access and Resources Together (SMART) Act, which mandates adjustments to any rate of reimbursement for services or other payments to hospitals with certain limited exceptions. The Department is also proposing to continue to implement the potentially preventable readmission (PPR) policy as required by SMART. This policy is designed to reduce potentially preventable hospital readmissions, inpatient complications and unnecessary emergency room visits.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

The full text of the Adopted Amendments begins on the next page:

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## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## SUBCHAPTER e: GENERAL TIME-LIMITED CHANGES

## PART 152

## HOSPITAL REIMBURSEMENT CHANGES

## Section

152.100	<del>Hospital Rate Reductions Reimbursement Add-on Adjustments (Repealed)</del>
152.150	Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
152.200	Non-DRG Reimbursement Methodologies
152.250	Appeals (Repealed)
<u>152.300</u>	<u>Adjustment for Potentially Preventable Readmissions</u>

AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Sections 12-13 and 14-8 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and Sections 12-13 and 14-8].

SOURCE: Emergency rules adopted at 18 Ill. Reg. 2150, effective January 18, 1994, for maximum of 150 days; adopted at 18 Ill. Reg. 10141, effective June 17, 1994; emergency amendment at 19 Ill. Reg. 6706, effective May 12, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10236, effective June 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16272, effective November 27, 1995; emergency amendment at 20 Ill. Reg. 9272, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15712, effective November 27, 1996; emergency amendment at 21 Ill. Reg. 9544, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16153, effective November 26, 1997; emergency amendment at 25 Ill. Reg. 218, effective January 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6966, effective May 28, 2001; emergency amendment at 25 Ill. Reg. 16122, effective December 3, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 7309, effective April 29, 2002; emergency amendment at 29 Ill. Reg. 10299, effective July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19997, effective November 23, 2005; emergency amendment at 30 Ill. Reg. 11847, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18703, effective November 27, 2006; emergency amendment at 32 Ill. Reg. 529, effective January 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 8730, effective May 29, 2008; amended at 35 Ill. Reg. 10114, effective June 15, 2011; emergency amendment at 36 Ill. Reg. 10410, effective July 1, 2012 through June 30, 2013; emergency amendment at 37 Ill. Reg. 282, effective January 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 10517, effective June 27, 2013.

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**Section 152.100 Hospital Rate Reductions Reimbursement Add-on Adjustments (Repealed)**

Notwithstanding any provision to the contrary in 89 Ill. Adm. Code 148 and 149 and this Part 152, effective for dates of service on or after July 1, 2012, any rate of reimbursement for services to hospitals or other payments to hospitals shall be reduced by an additional 3.5% from the rates that were otherwise in effect on July 1, 2012, except that those reductions shall not apply to:

- a) Rates or payments for hospital services delivered by a hospital defined as a Safety Net Hospital under Section 5-5e.1 of the Illinois Public Aid Code [305 ILCS 5].
- b) Rates or payments for hospital services delivered by a hospital defined as a Critical Access Hospital that is an Illinois hospital designated as a critical care hospital by the Department of Public Health in accordance with 42 CFR 485, subpart F.
- c) Rates or payments for hospital services delivered by a hospital that is operated by a unit of local government or State university that provides some or all of the non-federal share of the services.
- d) Payments authorized under Section 5A-12.4 of the Public Aid Code.

(Source: Added at 37 Ill. Reg. 10517, effective June 27, 2013)

**Section 152.200 Non-DRG Reimbursement Methodologies**

- a) Notwithstanding any provisions set forth in 89 Ill. Adm. Code 148, the changes described in subsection (b) of this Section will be effective January 18, 1994.
- b) All per diem payments calculated under 89 Ill. Adm. Code 148, except for those described in 89 Ill. Adm. Code 148.120, 148.160, 148.170, 148.175 and 148.290(a), (c) and (d), in effect on January 18, 1994, less the portion of such rates attributed by the Department to the cost of medical education, shall remain in effect hereafter.
- c) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 148, Hospital Services, and 89 Ill. Adm. Code 146, Subpart A, Ambulatory Surgical Treatment Centers, the changes described in this subsection (c) shall be effective January 1, 2001. Payments for hospital inpatient and outpatient services and ambulatory surgical treatment services shall not exceed charges to the Department. This

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payment limitation shall not apply to government owned or operated hospitals or children's hospitals as defined at 89 Ill. Adm. Code 149.50(c)(3). This payment limitation shall not apply to or affect disproportionate share payments as described at 89 Ill. Adm. Code 148.120, payments for outlier costs as described at 89 Ill. Adm. Code 148.130 or payments for Medicaid High Volume Adjustments as described at 89 Ill. Adm. Code 148.290(d).

- d) Notwithstanding the provisions of subsections (a), (b) and (c) of this Section, payment for outlier adjustments provided for exceptionally costly stays pursuant to 89 Ill. Adm. Code 148.130 shall be determined using the following factors:
- 1) For admissions on December 3, 2001 through June 30, 2005, a factor of 0.22 in place of the factor 0.25 described at 89 Ill. Adm. Code 148.130(b)(3)(D).
  - 2) For admissions on or after July 1, 2005 through June 30, 2006, a factor of 0.20 in place of the factor 0.22 as described in subsection (d)(1) of this Section.
  - 3) For admissions on or after July 1, 2006 through December 31, 2007, a factor of 0.18 in place of the factor 0.20 as described in subsection (d)(2) of this Section.
  - 4) For admissions on or after January 1, 2008, a factor of 0.17 in place of the factor 0.18 as described in subsection (d)(3) of this Section.
- e) Notwithstanding any other provisions of 89 Ill. Adm. Code 148 or 149 or this Part, long term acute care supplemental per diem rates, as authorized under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], effective July 1, 2012, shall be the amount in effect as of October 1, 2010. The July 1, 2012 rate will then be subject to the rate reductions detailed in Section 152.100. No new hospital may qualify under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act after June 14, 2012.
- f) Notwithstanding any other provisions of 89 Ill. Adm. Code 148 or 149 or this Part, a hospital that is located in a county of the State in which the Department mandates some or all of its beneficiaries of the Medical Assistance Program residing in the county to enroll in a Care Coordination Program, as defined in Section 5-30 of the Public Aid Code, shall not be eligible for any non-claims

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based payments not mandated by Article V-A of the Public Aid Code that it would otherwise be qualified to receive, unless the hospital is a Coordinated Care Participating Hospital as defined in 89 Ill. Adm. Code 148.295(g)(5), no later than August 14, 2012 or 60 days after the first mandatory enrollment of a beneficiary in a Coordinated Care Program.

(Source: Amended at 37 Ill. Reg. 10517, effective June 27, 2013)

**Section 152.300 Adjustment for Potentially Preventable Readmissions**

- a) Notwithstanding any provision set forth in 89 Ill. Adm. Code 148 or 149, the changes described in this Section will be effective January 1, 2013.
- b) For clean claims received on or after January 1, 2013, rates of payment to hospitals that have an excess number of readmissions, as defined in accordance with the criteria set forth in subsection (d), as determined by a risk adjusted comparison of the actual and targeted number of readmissions in a hospital as described by subsection (e), shall be reduced in accordance with subsection (f).
- c) Definitions. For purposes of this Section, the following terms are defined in this subsection (c). The definitions manual applicable to the PPR software created and maintained by the 3M Corporation that HFS will use to process admissions data and determine whether an admission is a Potentially Preventable Readmission can be accessed at [www.aprdrgassign.com](http://www.aprdrgassign.com).
  - 1) "Potentially Preventable Readmission" or "PPR" shall mean a readmission meeting the readmission criteria in subsection (d) that follows a prior discharge from a hospital within 30 days and that is clinically-related to the prior hospital admission.
  - 2) "Hospital" shall mean a hospital as defined in 89 Ill. Adm. Code 148.25(b).
  - 3) "Clean Claim" shall mean a claim as defined in 42 CFR 447.45(b).
  - 4) "Clinically Related" shall mean that the underlying reason for readmission is plausibly related to the care rendered during a prior hospital admission. A clinically-related readmission results from the process of care and treatment provided during the prior admission (e.g., readmission for a

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surgical wound infection) or from a lack of post-admission follow up (e.g., lack of follow-up care arrangements with a primary physician) rather than from unrelated events that occurred after the prior admission (such as a broken leg due to trauma) within a specified readmission time interval.

- 5) "Initial Admission" shall mean an admission to a hospital that is followed by a subsequent readmission or readmissions within 30 days that are determined by the 3M Corporation's PPR methodology to be clinically related.
- 6) "Only Admission" shall mean an admission without an associated readmission.
- 7) "Potentially Preventable Readmission Chain" or "PPR Chain" shall mean an initial admission occurring at a hospital that is followed by one or more clinically-related PPRs. The PPRs may occur at the same hospital or a different hospital.
- 8) "Qualifying Admission" shall mean the number of PPR chains plus the number of "Only Admissions", but specifically excludes the admissions detailed in subsection (d)(2).
- 9) "Actual Rate" shall mean the number of PPR chains for a hospital divided by the total number of qualifying admissions for the hospital.
- 10) "Targeted Rate of Readmissions" shall mean a risk adjusted readmission rate for each hospital that accounts for the severity of illness, APR-DRG, presence of behavioral health issues, and age of patient at the time of discharge preceding the readmission.
- 11) "Excess Rate of Readmission" shall mean the difference between the actual rate of readmission and the targeted rate of readmission for each hospital.
- 12) "Behavioral Health", for the purposes of risk adjustments, shall mean an admission that includes a secondary diagnosis of a major behavioral health related condition, including, but not limited to, mental disorders, chemical dependency and substance abuse.

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d) Readmission Criteria

- 1) A readmission is defined as an inpatient readmission within 30 days after discharge that is clinically related to the initial admission, as defined by the PPR software created and maintained by the 3M Corporation, and meets all of the following criteria:
  - A) The readmission is potentially preventable by the provision of appropriate care consistent with accepted standards, based on the 3M software, in the prior discharge or during the post-discharge follow-up period.
  - B) The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge.
  - C) The readmission is to the same or to any other hospital.
- 2) Admissions data, for the purposes of determining PPRs, excludes the following circumstances:
  - A) The discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of the discharge and readmission are documented in the patient's medical record.
  - B) The admission was for the purpose of securing treatment for a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions, HIV, alcohol or drug detoxification, non-acute events (rehabilitation admissions), or, for hospitals defined in 89 Ill. Adm. Code 149.50(c)(4), admissions with an APR-DRG code other than 740 through 760.
  - C) The admission was for an individual who was dually eligible for Medicare and Medicaid, or was enrolled in a Managed Care Organization (MCO).
- 3) Non-events are admissions to a non-acute care facility, such as a nursing home, or an admission to an acute care hospital for non-acute care. Non-events are ignored and are not considered to be readmissions.

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- 4) Planned readmissions, as defined by 3M's team of clinicians, are accounted for in the 3M PPR software as an "Only Admission" and are not considered to be readmissions.
- e) Methodology to Determine Excess Readmissions
- 1) Rate adjustments for State fiscal year 2013 for each hospital shall be based on each hospital's 2010 medical assistance paid claims data for admissions that occurred between July 1, 2009 and June 30, 2010.
  - 2) Except as otherwise provided in subsection (f)(8), the targeted rate of readmission for each hospital shall be reduced by the percent necessary to achieve a savings of at least \$40 million in State fiscal year 2013 for hospitals other than the "large public hospitals" defined in 89 Ill. Adm. Code 148.458(a).
  - 3) Excess readmissions for each hospital shall be calculated by multiplying a hospital's qualifying admissions by the difference between the actual rate of PPRs and the targeted rate of PPRs, as adjusted in subsection (e)(2).
  - 4) In the event the actual rate of PPRs for a hospital is lower than the targeted rate of PPRs, the excess number of readmissions shall be set at zero.
- f) Payment Reduction Calculation
- 1) An average readmission payment per PPR chain for each hospital shall be calculated by dividing the total medical assistance net liability attributable to the readmissions associated with the hospital's PPR chains (excluding the liability associated with the initial admission) by the number of PPR chains for the hospital.
  - 2) The total excess readmission payments shall equal the average readmission payment per PPR chain, as determined in subsection (f)(1) multiplied by the excess readmissions as determined in subsection (e)(3).
  - 3) The total annual payment reduction for each hospital shall be the lesser of:

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- A) The total excess readmission payments as determined in subsection (f)(2); or
- B) The total medical assistance payments for all hospital admissions, including admissions that were excluded from the PPR analysis, multiplied by 7%.
- 4) A fiscal year 2013 hospital specific payment reduction factor for each hospital shall be computed as one minus the arithmetic operation of 25% of the total annual payment reduction, as determined in subsection (f)(3), divided by 50% of the total estimated medical assistance payments for all hospital clean claims received in fiscal year 2013.
- 5) The hospital specific payment reduction factor, as determined in subsection (f)(4), shall be applied to the final payment amount for each clean claim received in fiscal year 2013.
- 6) In order to achieve a savings of 25% of the annual payment reduction for each hospital, the hospital specific payment reduction factor may be adjusted to account for variances between the estimated payments to the hospital and the actual payments to the hospital.
- 7) For those hospitals that have a payment reduction amount in State fiscal year 2013, a reconciliation of fiscal year 2013 claims will be calculated after January 1, 2014, after all inpatient hospital claims have been received by the Department, to determine how much of the remaining annual payment reduction must be recovered from the hospital. This reconciliation will determine how much of the annual payment reduction was offset in fiscal year 2013 by comparing the fiscal year 2013 rate of readmission to the base year (fiscal year 2010), as determined by subsection (e)(2). In addition, the reconciliation will account for changes in the average readmission payment per PPR chain from fiscal year 2010 to fiscal year 2013.
- 8) After the Department verifies that all hospitals have achieved \$40 million savings in aggregate for FY2013 when compared to the base year, no further payment reductions will be applied to individual hospitals.

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- g) Prior to June 30, 2013, administrative rules will be filed to determine the PPR adjustment methodology for fiscal year 2014 and thereafter.

(Source: Added at 37 Ill. Reg. 10517, effective June 27, 2013)

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## NOTICE OF ADOPTED AMENDMENT

- 1) Heading of the Part: Long Term Care Reimbursement Changes
- 2) Code Citation: 89 Ill. Adm. Code 153
- 3) Section Number: 153.126                      Adopted Action:  
Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: February 1, 2013; 37 Ill. Reg. 1112
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were needed.
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? Yes, July 13, 2012; 36 Ill. Reg. 10416
- 14) Are there any other rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: These administrative rules are authorized by SMART which mandates adjustments to rates for the services provided by the long term care facilities identified in this rulemaking.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Jeanette Badrov

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

The full text of the Adopted Amendment begins on the next page:

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENT

## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## SUBCHAPTER e: GENERAL TIME-LIMITED CHANGES

## PART 153

## LONG TERM CARE REIMBURSEMENT CHANGES

## Section

153.100	Reimbursement for Long Term Care Services
153.125	Long Term Care Facility Rate Adjustments
153.126	Long Term Care Facility Medicaid Per Diem Adjustments
153.150	Quality Assurance Review (Repealed)

AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and 12-13].

SOURCE: Emergency rules adopted at 18 Ill. Reg. 2159, effective January 18, 1994, for maximum of 150 days; adopted at 18 Ill. Reg. 10154, effective June 17, 1994; emergency amendment at 18 Ill. Reg. 11380, effective July 1, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16669, effective November 1, 1994; emergency amendment at 19 Ill. Reg. 10245, effective June 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16281, effective November 27, 1995; emergency amendment at 20 Ill. Reg. 9306, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 14840, effective November 1, 1996; emergency amendment at 21 Ill. Reg. 9568, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13633, effective October 1, 1997; emergency amendment at 22 Ill. Reg. 13114, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16285, effective August 28, 1998; amended at 22 Ill. Reg. 19872, effective October 30, 1998; emergency amendment at 23 Ill. Reg. 8229, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12794, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13638, effective November 1, 1999; emergency amendment at 24 Ill. Reg. 10421, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15071, effective October 1, 2000; emergency amendment at 25 Ill. Reg. 8867, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 14952, effective November 1, 2001; emergency amendment at 26 Ill. Reg. 6003, effective April 11, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 12791, effective August 9, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11087, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17817, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 11088, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18880, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 10218,

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effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 15584, effective November 24, 2004; emergency amendment at 29 Ill. Reg. 1026, effective January 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 4740, effective March 18, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 6979, effective May 1, 2005; amended at 29 Ill. Reg. 12452, effective August 1, 2005; emergency amendment at 30 Ill. Reg. 616, effective January 1, 2006, for a maximum of 150 days; emergency amendment modified pursuant to the Joint Committee on Administrative Rules Objection at 30 Ill. Reg. 7817, effective April 7, 2006, for the remainder of the maximum 150 days; amended at 30 Ill. Reg. 10417, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11853, effective July 1, 2006, for a maximum of 150 days; emergency expired November 27, 2006; amended at 30 Ill. Reg. 14315, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 18779, effective November 28, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 6954, effective April 26, 2007; emergency amendment at 32 Ill. Reg. 535, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 4105, effective March 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 7761, effective May 5, 2008; amended at 32 Ill. Reg. 9972, effective June 27, 2008; amended at 33 Ill. Reg. 9347, effective July 1, 2009; emergency amendment at 34 Ill. Reg. 17462, effective November 1, 2010, for a maximum of 150 days; amended at 35 Ill. Reg. 6171, effective March 28, 2011; amended at 35 Ill. Reg. 19524, effective December 1, 2011; emergency amendment at 36 Ill. Reg. 10416, effective July 1, 2012 through June 30, 2013; amended at 36 Ill. Reg. 17405, effective December 1, 2012; amended at 37 Ill. Reg. 10529, effective June 27, 2013.

**Section 153.126 Long Term Care Facility Medicaid Per Diem Adjustments**

- a) Notwithstanding the provisions set forth in Section 153.100, the socio-development component for facilities that are federally defined as Institutions for Mental Disease (see 89 Ill. Adm. Code 145.30) shall be increased by 253 percent beginning with services provided on and after March 1, 2008.
- b) Notwithstanding the provisions set forth in Section 153.100, daily residential rates effective on March 1, 2008, for intermediate care facilities for persons with developmental disabilities (ICF/DD), including skilled nursing facilities for persons under 22 years of age (SNF/Ped), for which a patient contribution is required, shall be increased by 2.2 percent.
- c) Notwithstanding the provisions set forth in Section 153.100, developmental training rates effective on March 1, 2008 shall be increased by 2.5 percent.
- d) Notwithstanding the provisions set forth in Sections 153.100 and 153.125, for

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dates of services provided on or after July 1, 2012, the \$10 per day per individual payment for individuals with developmental disabilities in nursing facilities, described in 89 Ill. Adm. Code 147.350, shall be eliminated.

- e) Notwithstanding the provisions set forth in Sections 153.100 and 153.125, on or after July 1, 2012, nursing facilities not designated as Institutions for Mental Disease shall have rates effective May 1, 2011 (see Section 153.125) adjusted as follows:
- 1) Individual nursing rates for residents classified in Resource Utilization Groups IV (RUG-IV) PA1, PA2, BA1 and BA2, during the quarter ending March 31, 2012, shall be reduced by 10 percent;
  - 2) Individual nursing rates for residents classified in all other RUG-IV groups shall be reduced by 1.0 percent; and
  - 3) Facility rates for the support and capital components shall be reduced by 1.7 percent.
- f) Notwithstanding the provisions set forth in Sections 153.100 and 153.125, on or after July 1, 2012, nursing facilities designated as Institutions for Mental Disease and facilities licensed under the Specialized Mental Health Rehabilitation Act shall have the nursing, socio-development, capital and support components of their reimbursement rate effective May 1, 2011 (see Section 153.125), reduced in total by 2.7 percent.
- g) Notwithstanding the provisions set forth in Sections 153.100 and 153.125, on or after July 1, 2012, supported living facilities, as defined in 89 Ill. Adm. Code 146.205, shall have rates reduced by 2.7 percent.

(Source: Amended at 37 Ill. Reg. 10529, effective June 27, 2013)

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## NOTICE OF ADOPTED RULES

- 1) Heading of the Part: Insurance Oversight Data Collection
- 2) Code Citation: 50 Ill. Adm. Code 2907
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
2907.10	New
2907.20	New
2907.30	New
2907.40	New
2907.APPENDIX A	New
2907.APPENDIX B	New
- 4) Statutory Authority: Implementing and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/ 401] and Section 29.2(b) of the Workers Compensation Act [820 ILCS 305/29.2(b)]
- 5) Effective Date of Rulemaking: June 26, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.
- 9) Notice of Proposal published in the *Illinois Register*: 36 Ill. Reg. 9749; July 6, 2012
- 10) Has JCAR issued a Statement of Objections to this Rulemaking? No
- 11) Differences between Proposal and Final Version:
  - a) Appendix A: added column to the right of "Data Definition" column; added title "Data Based On" in the first row of the new column.
  - b) Fields 1 and 2, column 3, change the single quotes to double quotes.
  - c) Field 4, 1st column, changed "4" to "4a"; 2<sup>nd</sup> column, added "Name" after "Contact".

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d) Added a row for field 4b:

4b	Company Contact Phone Number	Character value "(000) 000-0000"	
----	---------------------------------	----------------------------------	--

- e) Field 6, change column 3 to "A claim received by the insurer during the survey period".
- f) Field 7, 3<sup>rd</sup> column, changed "that are opened during the survey period" to "reported in field #6".
- g) Field 8, 3<sup>rd</sup> column, changed "that are opened during the survey period" to "reported in field #6"); after "or" added "in which".
- h) Field 9, column 3, changed "insured" to employee".
- i) Fields 10a, 10b and 10c, column 3, changed "insured" to employee".
- j) Fields 10b and 10c, column 3, changed "working" to "calendar".
- k) Field 11, changed "man-hours" to "person hours".
- l) Fields 6, 7, 8, 10 and 12, 4<sup>th</sup> column, added "Claims opened".
- m) Field 13b, column 3, changed "above" to "in field #13a".
- n) Field 14a, 3<sup>rd</sup> column, changed "internal defense counsel expenses were paid on, applied to, or associated with" to "open at any time; line 3, after "period", added "in which internal counsel was utilized".
- o) Field 14b, 3<sup>rd</sup> column, changed "The total amount of" to "Total expenses (actual or estimated) applied to"; lines 1-2, delete all text after "defense" and add "counsel activities associated with the claims reported in field #14a".
- p) Field 15a, 3<sup>rd</sup> column, deleted all text after "claims"; added "open at any time during the survey period in which external (i.e., outside) defense counsel was utilized".

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- q) Field 15b, changed "The total amount of all defense costs" to "Total expenses (actual or estimated) applied to all external defense counsel activities associated"; 3rd line, deleted "above"; after "claims", added "reported in field #15a".
- r) Field 16a, added "of fees" after "amount", changed "for" to "in connection with"; added ":" after "period"; added the following text starting on the next line:
- 1) Review individual bills and identify charges in excess of the Workers' Compensation Commission Fee Schedule.
  - 2) Review individual bills and identify improperly applied Managed Care discount.
  - 3) Review individual bills and identify medically unnecessary procedures.
  - 4) Review individual bills and identify improperly coded medical procedures.
  - 5) Review individual bills and identify medical providers who provide excessive utilization of their services.
  - 6) Review individual bills and identify medical procedures not covered by the Workers' Compensation Commission Fee Schedule.
  - 7) Review bills and identify duplications.
  - 8) Re-price pharmaceutical services based on a reliable method.
  - 9) Track prescription usage and alerts concerning potential abuse.
  - 10) Review bills not covered under the Fee Schedule and determine if the provider has charged according to reasonable and customary rates.
- s) Field 16b, 3<sup>rd</sup> column, deleted "for bill review"; changed "all medical bill review services during the survey period" to "services described in field #16(a) during the survey period".
- t) Field 17, 3<sup>rd</sup> column, changed "allocated expenses for" to "fees billed to employers in connection with"; added "discount" after "schedule"; deleted "provided by the insurer during the survey period".
- u) Field 18, 3<sup>rd</sup> column, deleted all text after "The total amount of" and added "allocated for services provided by a Workers' Compensation Preferred Provider Program as defined in 50 Ill. Adm. Code 2051.220".
- v) Field 19b, 3<sup>rd</sup> column, changed "above claims" to "claims reported in field #19a".
- w) Field 20b, column 3, changed "above" to "reported in field #20a".

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- x) Fields 9, 11, 13a, 13b, 14a, 14b, 15a, 15b, 16a, 16b, 17, 18, 19a, 19b, 20a, 20b, 21, 22 and 23, 4<sup>th</sup> column, added "All claims".
  - y) Table below line 82: 1<sup>st</sup> row, 4<sup>th</sup> column, added "Name" after "Contact"; 2<sup>nd</sup> row, changed "4" to "4a".
  - z) After 4<sup>th</sup> column, added a column; in the new column, added "Company Contact Phone Number" in Row 1 and "4b" in Row 2.
  - aa) Above Field 11, changed "Man-Hours" to "Person Hours".
- 12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace an emergency rulemaking currently in effect? No
- 14) Are there any proposed rulemakings pending on this Part? No
- 15) Summary and Purpose of rulemaking: Pursuant to 820 ILCS 305/29.2(b), the Director shall promulgate rules requiring each insurer licensed to write workers' compensation coverage in the State to record and report the information requested in this Section. This rule intends to provide guidance and clarification to companies pertaining to the mandated information being submitted to the Department.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Robert Rapp  
Supervisor, Market Analysis Section  
Department of Insurance  
320 West Washington Street  
Springfield, Illinois 62767-0001

217/785-1680

The full text of the Adopted Rules begins on the next page.

## DEPARTMENT OF INSURANCE

## NOTICE OF ADOPTED RULES

## TITLE 50: INSURANCE

## CHAPTER I: DEPARTMENT OF INSURANCE

## SUBCHAPTER hh: WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY

## PART 2907

## INSURANCE OVERSIGHT DATA COLLECTION

## Section

2907.10	Applicability
2907.20	Purpose and Scope
2907.30	Reporting Requirement
2907.40	Coding Conventions for the Insurance Oversight Workers' Compensation Data Collection
2907.APPENDIX A	Data Element Definitions
2907.APPENDIX B	Sample Table

AUTHORITY: Implementing and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401] and Section 29.2(b) of the Workers' Compensation Act [820 ILCS 305/29.2(b)].

SOURCE: Adopted at 37 Ill. Reg. 10534, effective June 26, 2013.

**Section 2907.10 Applicability**

This Part shall apply to each company licensed to write workers' compensation insurance in this State pursuant to Section 4, Class 2(d) of the Illinois Insurance Code [215 ILCS 5/4]. These procedures are applicable to all workers' compensation insurance written by insurers licensed by the State of Illinois. The data filings are not to include premiums received from, or losses paid to, other insurers because of the reinsurance assumed by the reporting insurers; nor shall any deductions be made by the reporting insurers for premiums ceded to, or for losses recovered from, other insurers because of the reinsurance ceded.

**Section 2907.20 Purpose and Scope**

The purpose of this Part is to establish content, form and data reporting requirements for information required to be reported to the Director of the Illinois Department of Insurance (Director) pursuant to Section 29.2(b) of the Workers' Compensation Act (Act) [820 ILCS 305/29.2(b)]. This Part will also establish the medium by which this information shall be transmitted to the Director.

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**Section 2907.30 Reporting Requirement**

- a) **Scope of Procedure**  
Pursuant to Section 29.2 (b) of the Act, the Director shall promulgate rules requiring each insurer licensed to write workers' compensation coverage in the State to record and report information on an aggregate basis to the Department of Insurance (Department) before March 1 of each year, relating to claims in the State opened within the prior calendar year.
- b) Specific data elements to be reported are defined in Appendix A.
- c) In the event that a company files inaccurate or incomplete data or there is some other problem with the data that is filed, a company may need to re-file its data with the Department. When this occurs, either at the request of the Department or upon initiation by the company, the company shall provide the Department with a narrative discussion of the reason for the re-file. This narrative shall be in the form of an email directed to appropriate Department staff.

**Section 2907.40 Coding Conventions for the Insurance Oversight Workers' Compensation Data Collection**

For 2013, data described in Section 2907.30 shall be filed with the Director no later than September 1, 2013. Beginning in 2014, all data described in Section 2907.30 shall be filed annually with the Director by March 1 for each preceding calendar year. The data must be submitted to the Department electronically in a Comma Separated Values (.csv) format. A sample table illustrating the format of the data is included in Appendix B. A template for the data submission is available on the Department's website at <http://insurance.illinois.gov/>.

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**Section 2907.APPENDIX A Data Element Definitions**

<b>Field #</b>	<b>Data Field</b>	<b>Data Definition</b>	<b>Date Based On:</b>
1	Company NAIC #	Character value 5 digits "00000"	
2	Company FEIN	Character value 10 digits "00-0000000"	
3	Company Name	Character value any length	
4a	Company Contact Name	Character value any length	
4b	Company Contact Phone Number	Character value "(000) 000-0000"	
5	Company Contact email	Character value any length	
6	# of claims opened	A claim received by the insurer during the survey period	Claims opened
7	# of reported medical only claims	The number of claims reported in field #6 in which recovery was limited to medical expenses only	Claims opened
8	# of contested claims	The number of claims reported in field #6 in which resolution was delayed due to a dispute regarding policy language or in which litigation was involved	Claims opened
9	# of claims for which the employee has attorney representation	The number of claims that are opened during the survey period in which the insurer has received notice that the employee has retained legal counsel	All claims

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10a	# of claims with lost time and # of claims for which temporary total disability was paid	a) The number of claims that are opened during the survey period in which the employee incurred time off of less than 3 working days	Claims opened
10b		b) The number of claims that are opened during the survey period in which the employee incurred time off of between 3 and 14 calendar days	
10c		c) The number of claims that are opened during the survey period in which the employee incurred time off of greater than 14 calendar days	
11	# of claim adjusters employed to adjust workers' compensation claims	The total number of person hours allocated to adjust workers' compensation claims received by the company during the survey period	All claims
12	# of claims for which temporary total disability was not paid within 14 days from the first full day off, regardless of reason	The number of temporary total disability claims that are opened during the survey period in which temporary total disability benefits were not paid within 14 days from the first full day off, regardless of reason	Claims opened
13a	# of medical bills paid 60 days or later from date of service	a) The total number of medical bills paid during the survey period when the time between the date of service and the date paid was greater than 60 days	All claims
13b	The average days paid on those paid after 60 days for the previous calendar year	b) The average number of days for all claim payments identified in field #13a	All claims

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14a	# of claims in which in-house defense counsel participated	a) The total number of claims open at any time during the survey period in which internal counsel was utilized	All claims
14b	Total amount spent on in-house legal services	b) Total expenses (actual or estimated) applied to all internal defense counsel activities associated with the claims reported in field #14a	All claims
15a	# of claims in which outside defense counsel participated	a) The total number of claims open at any time during the survey period in which external (i.e., outside) defense counsel was utilized	All claims
15b	Total amount paid to outside defense counsel	b) Total expenses (actual or estimated) applied to all external defense counsel activities associated with the claims reported in field #15a	All claims

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16a	Total amount billed to employers for bill review	<p>a) The total amount of fees billed to employers in connection with all medical bill review services provided by the insurer during the survey period:</p> <ol style="list-style-type: none"> <li>1) Review individual bills and identify charges in excess of the Workers' Compensation Commission Fee Schedule.</li> <li>2) Review individual bills and identify improperly applied Managed Care discount.</li> <li>3) Review individual bills and identify medically unnecessary procedures.</li> <li>4) Review individual bills and identify improperly coded medical procedures.</li> <li>5) Review individual bills and identify medical providers who provide excessive utilization of their services.</li> <li>6) Review individual bills and identify medical procedures not covered by the Workers' Compensation Commission Fee Schedule.</li> <li>7) Review bills and identify duplications.</li> <li>8) Re-price pharmaceutical services based on a reliable method.</li> <li>9) Track prescription usage and alerts concerning potential abuse.</li> <li>10) Review bills not covered under the Fee Schedule and determine if the provider has charged according to reasonable and customary rates.</li> </ol>	All claims
16b		<p>b) The total allocated expenses paid on behalf of employers for services described in field #16a during the survey period.</p>	
17	Total amount billed to employers for fee schedule savings	The total amount of fees billed to employers in connection with all fee schedule discount review services	All claims

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18	Total amount charged to employers for any and all managed care fees	The total amount of costs allocated for services provided by a Workers' Compensation Preferred Provider Program as defined in 50 Ill. Adm. Code 2051.220	All claims
19a	# of claims involving in-house medical nurse case management	a) The total number of claims internal medical nurse management expenses were applied to or associated with during the survey period, regardless of when the claim was opened	All claims
19b	The total amount spent on in-house medical nurse case management	b) The total amount of all internal nurse management expenses associated with the claims reported in field #19a	All claims
20a	# of claims involving outside medical nurse case management	a) The total number of claims external medical nurse management expenses were applied to or associated with during the survey period, regardless of when the claim was opened	All claims
20b	The total amount paid for outside medical nurse case management	b) The total amount of all outside nurse management expenses associated with the claims reported in field #20a	All claims
21	Total amount paid for independent medical exams	The total amount paid for all independent medical exams by the insurer during the survey period	All claims
22	Total amount spent on in-house Utilization Review for the previous calendar year	The total amount of all internal Utilization Review expenses incurred by the insurer during the survey period	All claims
23	Total amount paid for outside Utilization Review for the previous calendar year	The total amount of all external Utilization Review expenses incurred by the insurer during the survey period	All claims

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**Section 2907.APPENDIX B Sample Table**

## a) Data File Format

The sample table in subsection (b) provides a list of the required data elements for illustrative purposes only. Do not submit your data in this format. All files must be submitted electronically as specified in Section 2907.40. A template is available for use on the Department's website at <http://insurance.illinois.gov/>.

## b) Sample Table

NAIC #	FEIN	Company Name	Company Contact Name	Company Contact Phone Number	Contact email	Claims Opened	Medical Claims	Contested Claims
FIELD: 1	FIELD: 2	FIELD: 3	FIELD: 4a	FIELD: 4b	FIELD: 5	FIELD: 6	FIELD: 7	FIELD: 8

Client-Attorney	Breakdown of lost time by claim			Adjuster Person-Hours	Claims Paid Time Frame	Medical Payment Time Frame	
FIELD 9	FIELD: 10a	FIELD: 10b	FIELD: 10c	FIELD: 11	FIELD: 12	FIELD: 13a	FIELD: 13b

Internal Defense Council		External Defense Council		Bill Review Expenses		Fee Schedule Expenses	Managed Care Expenses
FIELD: 14a	FIELD 14b	FIELD: 15a	FIELD: 15b	FIELD: 16a	FIELD: 16b	FIELD: 17	FIELD: 18

Internal Medical Nurse Management		External Medical Nurse Management		Medical Exam Expenses	Internal Utilization Review Expenses	External Utilization Review Expenses
FIELD: 19a	FIELD: 19b	FIELD: 20a	FIELD: 20b	FIELD: 21	FIELD: 22	FIELD: 23

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Long-Term Care Assistants and Aides Training Programs Code
- 2) Code Citation: 77 Ill. Adm. Code 395
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
395.50	Amend
395.55	New
395.100	Amend
395.110	Amend
395.120	Amend
395.130	Amend
395.140	Amend
395.150	Amend
395.155	New
395.156	New
395.160	Amend
395.162	New
395.165	New
395.170	Amend
395.171	New
395.173	Amend
395.174	Amend
395.175	Amend
395.190	Amend
395.300	Amend
395.310	Repeal
395.320	Amend
395.400	Amend
- 4) Statutory Authority: Nursing Home Care Act [210 ILCS 45]
- 5) Effective Date of Rulemaking: June 27, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? Yes
- 8) A copy of the adopted rulemaking, including any material incorporated by reference, is on file in the Agency's principal office and is available for public inspection.

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- 9) Notice of Proposal published in the *Illinois Register*: 36 Ill. Reg. 10584; July 20, 2012
- 10) Has JCAR issued a Statement of Objections to this rulemaking? No
- 11) Differences between Proposal and Final Version: The following changes were made in response to comments received during the first notice or public comment period:

In Section 395.50, "Basic Child Care/Habilitation Aide Instructor – an individual who meets the requirements of Section 390.160 (c) of this Part and is approved by the Department of Human Services for a period of no more than two years." was removed.

In Section 395.50, "Course Coordinator (DSP Training Program) – a designated Department of Human Services individual who is responsible for the organization, management, and coordination of Direct Support Person (DSP) training. The course coordinator assures that training is in compliance with Department requirements, assures that required documentation is retained, and maintains linkage with the Department of Human Services. The course coordinator is not required to be an instructor." was inserted.

In Section 395.50, two definitions were inserted: "Direct Support Person (DSP) – any person who provides habilitative care, services, or support to individuals with developmental disabilities and is listed on the Department's Health Care Worker Registry as a trained DSP or DD Aide under its "Program" section. DSPs shall function under the supervision of a Qualified Intellectual Disabilities Professional (QIDP) or a Licensed/Registered Nurse. Other titles often used to refer to Direct Support Persons include, but are not limited to, Developmental Disabilities (DD) Aide, Habilitation/Child Care Aides, Mental Health Technician, Program Aide, or Program Technician." and "Direct Support Person Training Instructor – an individual who meets the requirements of Section 395.160(c) of this Part and is approved by the Department of Human Services."

In Section 395.50, "Other terms often used in place of "Interdisciplinary Team" include, but are not limited to, Community Support Team (CST), or Individual Education Plan (IEP)," was inserted after "needs."

In Section 395.50, the following definition was added: "Person-Centered Planning – a process whereby persons with disabilities and with the support of families direct the planning and allocation of resources to meet their own life vision and goals."

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In Section 395.50, "in keeping with the core values of Person-Centered Services. Other references used in place of "Plan of Care" include, but are not limited to, Individual Service Plan, Program Plan, or Individual Habilitation Plan" was inserted after "individual"

In Section 395.50, "or a QIDP who is approved by the Department of Human Services, Division of Developmental Disabilities based upon meeting the requirements of Section 395.160(c) of this Part" was inserted after "evaluator".

In Section 395.100, the following subsection was added: "d) A facility licensed by the Department under the ID/DD Community Care Act, or a program licensed or certified by the Department of Human Services as a Community Integrated Living Arrangement, a Family Assistance and Home-Based Support Program for Persons with Mental Disabilities, a Developmental Training Program, or a Medicaid Home and Community-Based Waiver Services Program for Individuals with Developmental Disabilities."

In Section 395.110, "E) Adequate space to provide the training component and not interfere with the individuals' activities." was inserted.

In Section 395.150, "five" was deleted and the strike-out was removed from "three".

In Section 395.162, "An Approved Evaluator shall have no fiduciary connection, within 30 days before or after the evaluation, with the facility at which the student is employed or will be employed" was changed to "Selected performance skills as determined by the Department shall then be evaluated by an Approved Outside Evaluator, who shall have no fiduciary connection, within 30 days before or after the evaluation, with the facility at which the student is employed or will be employed".

In Section 395.170, Subsection (a)(1)-(3), all the underscored language was removed and the existing language was stricken. The subsections in the rest of the Section were re-lettered accordingly.

In Section 295.171, an "a)" was inserted and "b) The program shall provide counseling to all individuals seeking admission to the program concerning the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. The counseling shall include, at a minimum:

- 1) Notification that a fingerprint-based criminal history records check will be initiated;

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- 2) A clear statement that a fingerprint-based criminal history records check is required for the individual to work as a direct access worker, a CNA, or a Direct Support Person in Illinois; and
- 3) A listing of those offenses in Section 25 of the Health Care Worker Background Check Act for which a conviction would disqualify the individual from finding employment as a direct access worker, a CNA, or a Direct Support Person unless the individual obtains a waiver pursuant to Section 40 of the Health Care Worker Background Check Act., was inserted.

In Section 395.300, "and the Physician's Order for Life Sustaining Treatment (POLST)" was inserted.

In Section 395.300, "and palliative care" was inserted after "hospice care".

In Section 395.300, "care and palliative care are" was inserted after "hospice" and "is" was removed.

The following changes were made in response to comments and suggestions of JCAR:

In Section 395.50, "DHS"- the Illinois Department of Human Services, and "DHS-DD" – the Illinois Department of Human Services-Division of Developmental Disabilities.", was added.

In addition, various typographical, grammatical, and form changes were made in response to the comments from JCAR.

- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: The Long-Term Care Assistants and Aides Training Programs Code regulates the training of Certified Nursing Assistants, Child

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Care/Habilitation aides, and Developmental Disabilities Aides, including minimum requirements for instructors and the curriculum.

The amendments were undertaken to update and revamp the minimum requirements for the Basic Nursing Assistant Training Program (Section 395.300), which have not been changed since 1993, and to add course requirements and a curriculum for a Train the Trainer program.

The other extensive updates to Part 395 amend nearly every Section, add six new Sections and repeal one Section, completely revamping the Code, particularly the requirements for instructors of training programs.

- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Susan Meister  
Division of Legal Services  
Department of Public Health  
535 West Jefferson, 5<sup>th</sup> Floor  
Springfield, Illinois 62761

217/782-2043  
e-mail: [dph.rules@illinois.gov](mailto:dph.rules@illinois.gov)

The full text of the Adopted Amendments begins on the next page:

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

TITLE 77: PUBLIC HEALTH  
 CHAPTER I: DEPARTMENT OF PUBLIC HEALTH  
 SUBCHAPTER c: LONG-TERM CARE FACILITIES

## PART 395

## LONG-TERM CARE ASSISTANTS AND AIDES TRAINING PROGRAMS CODE

## SUBPART A: PROGRAM APPLICATION AND APPROVAL PROCESS

## Section

395.50	Definitions
<u>395.55</u>	<u>Incorporated and Referenced Materials</u>
395.100	Program Sponsor
395.110	Application for Program Approval
395.120	Review Process and Program Approval
395.130	Review of Approved Training Program
395.140	Inactive Status
395.150	Minimum Hours of Instruction
<u>395.155</u>	<u>Train the Trainer Program (BNATP Only)</u>
<u>395.156</u>	<u>Train the Trainer Model Program (BNATP Only)</u>
395.160	Instructor Requirements
<u>395.162</u>	<u>Approved Evaluator (BNATP Only)</u>
<u>395.165</u>	<u>Program Coordinator (BNATP Only)</u>
395.170	Program Operation <u>(BNATP Only)</u>
<u>395.171</u>	<u>Health Care Worker Background Check</u>
395.173	Successful Completion of the Basic Nursing Assistant Training Program
395.174	Successful Completion of the <u>Direct Support Person</u> <del>Developmental Disabilities Aide or Basic Child Care/Habilitation Aide</del> Training Program
395.175	Program Notification Requirements <u>(BNATP Only)</u>
395.180	Department Monitoring (Repealed)
395.190	Denial, Suspension, and Revocation of Program Approval <u>(BNATP Only)</u>
395.200	Other Programs Conducted by Facilities (Repealed)

## SUBPART B: TRAINING PROGRAM CURRICULA REQUIREMENTS

## Section

395.300	Basic Nursing Assistant Training Program
395.310	Developmental Disabilities Aide Training Program <u>(Repealed)</u>
395.320	<u>Direct Support Person</u> <del>Basic Child Care/Habilitation Aide</del> Training Program

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- [\(BNATP Only\)](#)  
395.330 Psychiatric Rehabilitation Services Aide Training Program  
395.333 Waivered Psychiatric Rehabilitation Services Aide Training Program

## SUBPART C: PROFICIENCY EXAMINATION

- Section  
395.400 Proficiency Examination [\(BNATP Only\)](#)

AUTHORITY: Implementing and authorized by the Nursing Home Care Act [210 ILCS 45].

SOURCE: Adopted at 13 Ill. Reg. 19474, effective December 1, 1989; amended at 17 Ill. Reg. 2984, effective February 22, 1993; emergency amendment at 20 Ill. Reg. 529, effective January 1, 1996, for a maximum of 150 days; emergency expired May 29, 1996; amended at 20 Ill. Reg. 10085, effective July 15, 1996; amended at 22 Ill. Reg. 4057, effective February 13, 1998; amended at 25 Ill. Reg. 4264, effective March 20, 2001; amended at 26 Ill. Reg. 2747, effective February 15, 2002; ; amended at 26 Ill. Reg. 14837, effective October 15, 2002; amended at 37 Ill. Reg. 10546, effective June 27, 2013.

## SUBPART A: PROGRAM APPLICATION AND APPROVAL PROCESS

**Section 395.50 Definitions**

Ability-Centered Care – a comprehensive approach to attaining or maintaining the highest practicable physical, mental and psychosocial well-being, in which the resident's abilities and competencies are recognized and incorporated in a plan of care to adapt and modify tasks to provide for the resident's involvement at his or her maximum level.

Act – the Nursing Home Care Act [210 ILCS 45].

Activities of Daily Living or ADL – tasks performed on a day-to-day basis, including, but not limited to, eating, dressing, bathing, toileting, transferring or personal hygiene.

Alzheimer's Instructor – a registered nurse who is approved by the Department based upon meeting the Alzheimer's Instructor requirements of Section 395.160(b) and who is also an approved clinical instructor.

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Approved ~~Evaluator-evaluator~~ – a registered nurse who ~~is an approved clinical instructor and has completed-attended~~ a Department-sponsored evaluator workshop, ~~pursuant to Section 395.162meets the Instructor Requirements in Section 395.160 of this Part, and has no fiduciary connection with the facility by which the candidate is employed or will be employed within 30 days of the evaluation.~~

Approved Outside Evaluator – an Approved Evaluator who performs an evaluation of students in a training program sponsored by a long-term care facility, and who has no fiduciary connection, within 30 days before or after the evaluation, with the facility by which the student is employed.

Approved Performance Skills – tasks generally performed by certified nursing assistants (CNAs) for which competency must be demonstrated, including, but not limited to: wash hands; perform oral hygiene; shave a resident; perform nail care; perform perineal care; give a partial bath; give a shower or tub bath; make an occupied bed; dress a resident; transfer a resident to a wheelchair using a transfer belt; transfer a resident using a mechanical lift; help a resident to ambulate with a transfer belt; feed a resident; calculate intake and output; place a resident in a side-lying position; perform passive range of motion; apply and remove personal protective equipment; measure temperature, pulse and respiration; measure and record blood pressure; measure and record height; and measure and record weight.

Approved manual skills – the following tasks demonstrated by a candidate: washing hands, performing oral hygiene, hair care or nail care for a client, shaving a client's face, taking a client's oral temperature and pulse, measuring a client's respiration and blood pressure, making an occupied and unoccupied bed, feeding and dressing a client, making a final room check prior to client occupancy, measuring a client's weight and height, placing a client in a side-lying position, performing passive range of motion on a client, calculating a client's intake and output of fluids, transferring a client to a wheelchair using a safety belt, and giving a client a partial bath.

Asepsis – a condition in which living pathogenic organisms are absent.

Basic Nursing Assistant Training Program or BNATP – an approved course curriculum in a community college, community agency, or private business that prepares individuals for employment as CNAs.

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Cardiopulmonary Resuscitation Instructor or CPR Instructor – a person approved by the Department, or by the Department of Human Services-Division of Developmental Disabilities and who is certified in cardiopulmonary resuscitation at the health care provider level or health care provider instructor level by a nationally recognized program, by the Department or by DHS-DD.

Care – as used in this Part, the personal, restorative or rehabilitative treatment of a resident in a health care setting by a CNA.

Certified Nursing Assistant or CNA – an individual who does not hold a professional license from the Department of Financial and Professional Regulation, or someone who volunteers to provide licensed services without pay; an individual who was grandfathered in, or has successfully completed the BNATP and competency examination or has met the equivalency requirements of 77 Ill. Adm. Code 300.663 (Skilled Nursing and Intermediate Care Facilities Code); an individual who provides nursing or nursing-related services for monetary compensation under the clinical supervision of a licensed nurse; an individual who has not had a period of 24 consecutive months, since his or her most recent competency examination or the date of being grandfathered in, during which he or she did not provide nursing or nursing-related services for monetary compensation under the clinical supervision of a licensed nurse.

Child Care/Habilitation Aide – any person who provides nursing, personal or rehabilitative care to residents of licensed Long Term Care Facilities for Persons Under 22 Years of Age, regardless of title, and who is not otherwise licensed, certified or registered by the Department of Professional Regulation to render such care. Child Care/Habilitation aides must function under the supervision of a licensed nurse.

Clinical Conference – a conference of short duration held during a clinical instruction to communicate information regarding direct resident care. Theory content shall not be presented.

Clinical Instruction – a teaching method used by an approved clinical instructor in a clinical setting in which the student explains and demonstrates competency of skills learned during theory instruction to a level accepted by the instructor.

Clinical Instructor (BNATP Only) – a registered nurse who is approved by the

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Department based upon meeting the requirements of Section 395.160(a) and is an approved evaluator. This is the minimum requirement to teach the clinical component of the BNATP curriculum.

Competency Examination (CNA Only)-test – a comprehensive multiple choice test meeting the requirements of 42 CFR 483; and administered by the Department or its designee a school, agency or similar institution under a contract agreement with the Department. This examination shall be successfully completed within one year after the student's having completed the BNATP or having been deemed equivalent to a CNA through training or training and experience pursuant to 77 Ill. Adm. Code 300.663.

Clinical practice instruction – a teaching method used during the practical application of skill competencies (on-the-job training – OJT) in which the trainee explains and demonstrates skill competencies learned during the theory and OJT sections to an acceptable level in the presence of an OJT instructor.

CourseCurriculum Coordinator (CNA Training Program) – an individual in each Certified Nursing Assistant-Developmental Disabilities Aide Training Program; who is a qualified mental retardation professional who is responsible for planning, organization, management, coordination with training staff, compliance, documentation; and linkage with the Department and the Department of Mental Health and Developmental Disabilities. The Course Curriculum Coordinator is not required to be an instructor.

Course Coordinator (DSP Training Program) – a designated Department of Human Services individual who is responsible for the organization, management and coordination of Direct Support Person (DSP) training. The course coordinator assures that training is in compliance with Department requirements, assures that required documentation is retained, and maintains linkage with the Department of Human Services. The course coordinator is not required to be an instructor.

Cultural Competence – the ability to interact effectively with people of different cultures.

Department – the Illinois Department of Public Health.

DHS – the Illinois Department of Human Services.

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DHS-DD – the Illinois Department of Human Services-Division of Developmental Disabilities.

Developmental Disabilities (DD) Aide—any person who provides nursing, personal or habilitative care to residents of Intermediate Care Facilities for the Developmentally Disabled, regardless of title, and who is not otherwise licensed, certified or registered to render medical care. Other titles often used to refer to DD Aides include, but are not limited to, Program Aides, Program Technicians and Habilitation Aides. DD Aides must function under the supervision of a licensed nurse or a Qualified Mental Retardation Professional (QMRP).

Direct Access Worker – any individual who routinely has access to or has the ability or potential to have access to a resident, a resident's living quarters, or a resident's financial, medical or personal records through employment or through a contract with a facility or provider. A volunteer is included if the volunteer has duties that are equivalent to the duties of an employee or contracted worker who would be a direct access worker.

Direct Care – the provision of nursing care or assistance with feeding, dressing, movement, bathing, toileting or other personal needs, including home services as defined in the Home Health, Home Services and Home Nursing Agency Licensing Act.

Direct Contact ~~contact~~ – the provision of any services to a client by an individual carrying out tasks usually ~~performed done~~ by nursing assistants or Direct Support Persons, nurse aides

Direct Support Person or DSP – any person who provides habilitative care, services or support to individuals with developmental disabilities and is listed on the Department's Health Care Worker Registry as a trained DSP or DD Aide under its "Program" section. DSPs shall function under the supervision of a Qualified Intellectual Disabilities Professional (QIDP) or a Licensed/Registered Nurse. Other titles often used to refer to Direct Support Persons include, but are not limited to, Developmental Disabilities (DD) Aide, Habilitation/Child Care Aides, Mental Health Technician, Program Aide or Program Technician.

Direct Support Person Training Instructor or DSP Training Instructor – an individual who meets the requirements of Section 395.160(c) and is approved by

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DHS.

Evidence-Based Practice – recommended nursing interventions that have been shown to be effective when tested in clinical research.

Grandfathered CNA – an individual who has previously demonstrated to the satisfaction of the State that he or she had served as a nursing assistant at one or more facilities of the same employer in the State for at least 24 consecutive months before December 19, 1989. A grandfathered CNA may also be an individual who completed a training program before July 1, 1989 that would have met the requirements to be an approved training program if the approval had been offered at that time. Since the date the individual was grandfathered in as a CNA, that individual shall not have had a period of 24 consecutive months during which the individual did not provide nursing or nursing-related services for monetary compensation under the supervision of a licensed nurse. No additional individuals will be considered for grandfathered status.

Holistic Care – care that incorporates the whole person, i.e., physical, psychological, emotional and spiritual dimensions.

Home Health Aide – any person who meets the requirements of a CNA and provides part time and intermittent nursing services to a person in his or her residence according to a plan of treatment for illness or infirmity prescribed by a physician.

Interdisciplinary Team – a group of persons who represent those professions, disciplines or service areas that are relevant to identifying an individual's strengths and needs, and designs a program to meet those needs. This team shall include at least a physician and a social worker and may include other professionals. In programs serving individuals with developmental disabilities, at least one member of the team shall be a Qualified Intellectual Disabilities Professional. The interdisciplinary team includes the resident; the resident's guardian; the resident's primary service providers, including staff most familiar with the resident; and other appropriate professionals and care givers as determined by the resident's needs. Other terms often used in place of "Interdisciplinary Team" include, but are not limited to, Community Support Team (CST) or Individual Education Plan (IEP).

Laboratory Environment – a designated location for laboratory instruction that

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includes a minimum of one bed per five students, access to hand-washing facilities, and clinical instruction equipment and supplies.

Laboratory Instruction – a teaching method used during the theory section of the training program, requiring the student to demonstrate skill competencies in a supervised laboratory environment.

Lead Instructor – the theory instructor who is responsible for providing day-to-day management of the class.

Licensed Practical Nurse or LPN – a person with a valid license to practice as a licensed practical nurse under the Nurse Practice Act.

Methodologies – instructional methods by which content or curriculum information is to be presented in a BNATP, i.e., lecture, discussion, audiovisual, demonstration and group activities.

*Nurse – a registered nurse or a licensed practical nurse as defined in the Illinois Nursing Nurse Practice Act of 1987 [225 ILCS 65]. (Section 1-118 of the Act)*

Nursing Assistant Training and Competency Evaluation Program or NATCEP – a training and competency program consisting of an approved BNATP, demonstration of required performance skills and the written competency evaluation.

Nursing Care – activities, performed by a person licensed under the Nurse Practice Act, that carry out the diagnostic, therapeutic and rehabilitative plan prescribed by the physician; care for the resident's environment; observing symptoms and reactions; and taking necessary measures, including the delegation and supervision of tasks, to carry out nursing procedures involving understanding of cause and effect in order to safeguard life and health.

*Personal Care – assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual, who is incapable of maintaining a private, independent residence or who is incapable of managing his or her person whether or not a guardian has been appointed for such individual. (Section 1-120 of the Act)*

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Person-Centered Planning – a process through which persons with disabilities and with the support of families direct the planning and allocation of resources to meet their own life vision and goals.

Person-Centered Services – an approach to care focusing on individual rights and personal preferences.

Physician – any person licensed to practice medicine in all of its branches as provided by the Medical Practice Act of 1987 ~~[225 ILCS 60]~~.

Plan of Care – a strategy of action by the interdisciplinary team to address the needs of the individual, in keeping with the core values of Person-Centered Services. Other references used in place of "Plan of Care" include, but are not limited to, Individual Service Plan, Program Plan or Individual Habilitation Plan.

Plan of Correction – a written document, subject to the Department's or to DHS-DD's, approval, that addresses a situation, condition or practice constituting non-compliance by a training program. It shall include corrective actions specific to the cited deficiency, a procedure for implementation of the corrective actions, a monitoring procedure that ensures compliance with the requirements of this Part, the title of the person responsible for implementation, and the dated signature of the Program Coordinator.

Probation (BNATP Only) – an enforcement measure pursuant to Section 395.190, applied by the Department for non-compliance of a BNATP.

Program Cluster Scores Summary Reports – monthly, annual and biennial reports that provide a breakdown of training programs' examination results by specific content area for the purpose of program improvement and monitoring.

Program Coordinator (BNATP Only) – a registered nurse who is approved by the Department, based upon meeting the requirements of Section 395.165(a). This individual is responsible for the planning, implementation, evaluation and overall coordination of a BNATP.

Program Sponsor (BNATP Only) – an entity that has been approved by the Department to conduct an approved BNATP. The entity types that may be approved as a program sponsor are ascribed in Section 395.100.

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Psychiatric Rehabilitation Services Aide or PRSA – an individual who meets the training requirements of a Psychiatric Rehabilitation Services Aide as described in Section 395.330.

Qualified Intellectual Disabilities ~~Mental Retardation~~ Professional or QIDP – a person who meets the qualifications defined in 42 CFR 483.430(a). ~~has at least one year of experience working directly with individuals with developmental disabilities and meets at least one of the following additional qualifications:~~

~~Be a physician as defined in this Section.~~

~~Be a registered nurse as defined in this Section.~~

~~Hold at least a bachelor's degree in one of the following fields: occupational therapy, physical therapy, psychology, social work, speech or language pathology, recreation (or a recreation specialty area such as art, dance, music, or physical education), dietary services or dietetics, or a human services field (such as sociology, special education, or rehabilitation counseling).~~

Quality of Care – the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Quality of Life – care provided in a manner and in an environment that promote maintenance or enhancement of each resident's quality of life.

Registered ~~Nurse~~nurse or (RN) – a person with a valid license to practice as a registered professional nurse under the ~~Illinois Nurse Practice~~Illinois Nursing Act of 1987 [225 ILCS 65].

Resident or Client – A person who is receiving medical care, personal care, maintenance, or related services and supports. The term resident is used interchangeably in this Part to mean patient, client or person as appropriate to the regulatory setting. The term resident in this Part shall not be construed in any way to restrict the meaning to those living in long-term care facilities.

Special Content Instructor – a person who is approved by the Department or DHS to teach content related to his/her area of expertise, based upon meeting the

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requirements of Section 395.160(e).

Supervised laboratory – a teaching method utilized during the theory section of the program requiring the trainee to demonstrate skill competencies that were taught by the instructor as part of the theory section of the program.

Suspension – temporary withdrawal of a program sponsor's approval to offer training program classes.

Syllabus (BNATP Only) – a document provided to the students by the BNATP outlining information necessary for completion of the training program; this information shall include, but is not limited to, program policies and requirements, content outline and evaluation methods.

Theory Instruction (BNATP Only) – a teaching method using principles of education and learning in the classroom and laboratory environments to provide instruction to the student in accordance with the BNATP content outlined in Section 395.300. Theory instruction includes laboratory instruction and is provided by a Theory Instructor.

Theory Instructor – a registered nurse who is approved by the Department based upon meeting the requirements of Section 395.160 and is an approved evaluator or a QIDP who is approved by DHS-DD based upon meeting the requirements of Section 395.160(c).

Train the Trainer Instructor – a registered nurse who is approved by the Department based upon meeting the requirements of Section 395.155(f) and is an approved evaluator.

Train ~~the~~ The Trainer ~~Workshop~~/Program (BNATP Only) – a college-based program, ~~of no fewer~~ ~~less~~ than ~~3130~~ clock hours ~~excluding meals and breaks~~, designed to prepare a registered nurse to teach ~~in a BNATP~~ ~~certified nurse aide (CNA) students~~. ~~The Program~~ ~~course~~ includes ~~the Alzheimer's component and may include an Approved Evaluator Workshop~~. The Department will approve a Train the Trainer Program based upon the Program's meeting the requirements of Section 395.155. ~~learning principles, teaching methods, curriculum development and instructional techniques; or the Department sponsored program held prior to October 1991.~~

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Training Program (BNATP Only) – an approved course curriculum, conducted by a program sponsor, that has not been suspended, for training of Certified Nursing Assistants or Psychiatric Rehabilitation Services Aides.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.55 Incorporated and Referenced Materials**

- a) The following federal statutes are referenced in this Part:
- 1) Americans With Disabilities Act (42 USC 12101)
  - 2) Nursing Home Reform Amendments of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)
  - 3) Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191)
  - 4) Older Americans Act (Public Law 89-73)
- b) The following federal regulations are incorporated in this Part:
- 1) 42 CFR 483.151, State Review and Approval of Nurse Aide Training and Competency Evaluation Programs (October 1, 2010)
  - 2) 42 CFR 483.152, Requirements for Approval of a Nurse Aide Training and Competency Evaluation Program (October 1, 2010)
  - 3) 42 CFR 483.156, Registry of Nurse Aides (October 1, 2010)
  - 4) 42 CFR 483.430(a), Qualified Mental Retardation Professional (October 1, 2010)
- c) All incorporations by reference of federal regulations refer to the regulation on the date specified and do not include any amendments subsequent to the date specified.
- d) The following State statutes are referenced in this Part:

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- 1) [Nursing Home Care Act \[210 ILCS 45\]](#)
  - 2) [Nurse Practice Act \[225 ILCS 65\]](#)
  - 3) [Medical Practice Act of 1987 \[225 ILCS 60\]](#)
  - 4) [Private Business and Vocational Schools Act \[105 ILCS 425\]](#)
  - 5) [Hospital Licensing Act \[210 ILCS 85\]](#)
  - 6) [Home Health, Home Services, and Home Nursing Agency Licensing Act \[210 ILCS 55\]](#)
  - 7) [Health Care Worker Background Check Act \[225 ILCS 46\]](#)
  - 8) [Assisted Living and Shared Housing Act \[210 ILCS 9\]](#)
  - 9) [ID/DD Community Care Act \[210 ILCS 47\]](#)
  - 10) [Specialized Mental Health Rehabilitation Act \[210 ILCS 48\]](#)
  - 11) [Community Integrated Living Arrangements Licensure and Certification Act \[210 ILCS 135\]](#)
- e) [The following State rules are referenced in this Part:](#)
- 1) [Department of Public Health, Health Care Worker Background Check Code \(77 Ill. Adm. Code 955\)](#)
  - 2) [Department of Public Health, Practice and Procedure in Administrative Hearings \(77 Ill. Adm. Code 100\)](#)
  - 3) [Illinois Board of Higher Education, Private Business and Vocational Schools \(23 Ill. Adm. Code 1095\)](#)
  - 4) [Department of Human Services, Administration of Medication in Community Settings \(59 Ill. Adm. Code 116\)](#)

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- 5) Department of Human Services, Family Assistance and Home-Based Support Programs for Persons with Mental Disabilities (59 Ill. Adm. Code 117)
- 6) Department of Human Services, Minimum Standards for Certification of Developmental Training Programs (59 Ill. Adm. Code 119)
- 7) Department of Human Services, Medicaid Home and Community-Based Waiver Services Program for Individuals with Developmental Disabilities (59 Ill. Adm. Code 120)

(Source: Added at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.100 Program Sponsor**

Training program sponsors may be any one of the following:

- a) A community college or other public school operated by the ~~State~~ of Illinois or unit of local government.
- b) A private vocational or business school as defined in the Private Business and Vocational Schools Act ~~[105 ILCS 425]~~, which holds a valid certificate of approval or certificate of exemption issued by the ~~Illinois Board of Higher Education~~ State Board of Education under rules ~~titled~~ entitled "Private Business and Vocational Schools" (23 Ill. Adm. Code 451).
- c) A facility licensed by the Department under the Nursing Home Care Act, under the Hospital Licensing Act ~~[210 ILCS 85]~~ or under the Home Health, Home Services, and Home Nursing Agency Licensing Act ~~[210 ILCS 55]~~.
- d) A facility licensed by the Department under the ID/DD Community Care Act, or a program licensed or certified by DHS as a Community Integrated Living Arrangement, a Family Assistance and Home-Based Support Program for Persons with Mental Disabilities, a Developmental Training Program, or a Medicaid Home and Community-Based Waiver Services Program for Individuals with Developmental Disabilities.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

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**Section 395.110 Application for Program Approval**

- a) The program sponsor shall submit ~~ana letter of~~ application for program approval to ~~the each~~ Department ~~or DHS-DD~~ at least ~~90~~~~ninety~~ days in advance of the scheduled ~~or DHS-DD~~ beginning of the training program. If any part or portion of the originally approved program changes, a subsequent application for program approval shall be submitted to the appropriate Department at least 90 days in advance of the scheduled beginning of the new training program. The program sponsor shall not offer the training program prior to receipt of written approval from the Department ~~or DHS-DD~~. The appropriate Department will not grant retroactive approval of training programs.
- 1) The program sponsor shall submit an application for each theory site operating under its sponsorship.
  - 2) The program sponsor shall submit an application for each program type under its sponsorship (i.e., community college, adult vocational, secondary, facility based, or private business or vocational school).
- b) The ~~contents of the letter of~~ application will be prescribed by the Department or by DHS-DD and will~~shall~~ include at least the following information about the proposed program:
- 1) The type of~~A statement of whether the~~ training program being proposed ~~is~~ a:
    - A) Basic Nursing Assistant Training Program;
    - ~~B) Developmental Disabilities Aide Training Program;~~
    - ~~B)C) Direct Support Person Basic Child Care/Habilitation Aide Training Program;~~ or
    - i) Direct Support Person Training Program;
    - ii) Mental Health Technician Training Program;
    - iii) Program Technician Training Program; or
    - iv) Any other common name for this type of training program;

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or

~~C)D)~~ Psychiatric Rehabilitation Services Aide Training Program.

- 2) A copy of the sponsor's certificate of approval issued by the State Board of Education or the Board of Higher Education, as appropriate, if the sponsor is a private business, vocational school or college.
- 3) A summary statement of the program ~~rationale~~, including the philosophy, rationale and purpose of the program.
- 4) Either a~~A~~ statement indicating that the Department's model program based on Section 395.300 of this Part is being used or an outline containing the ~~methodology, content, and objectives~~, content and methodologies for the training program. In either case:
  - A) The outline or model program shall indicate the number of hours that will be dedicated to each component of the training program. This outline shall not preclude the instructor from varying the order of presentation of the outlined course components.
  - B) The outline or model program shall address each of the required curricula content requirements contained in Section 395.300 (Basic Nursing Assistant Training Program), ~~Section 395.310 (Developmental Disabilities Aides Training Program)~~, or Section 395.320 (~~Direct Support Person Training Basic Child Care/Habilitation Aide Training~~ Program) or Section 395.330 (Psychiatric Rehabilitation Services Aide Training Program).
- 5) A syllabus.
- 6) A completed master schedule, in a format prescribed by the Department or by DHS-DD, including, but not limited to for the training program, which includes at least the following:
  - A) Identification of the program coordinator or curriculum coordinator, with contact information;
  - ~~B)A)~~ The location of theory and clinical sites, classroom designation,

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and scheduled dates and times of the training program;-

~~C)B)~~ The allocation of the daily hours and total hours of instruction, differentiating between theory, ~~and~~ clinical instruction, and clinical conferences, excluding meals, breaks and field trips;-

~~D)C)~~ Identification of all instructors to be approved for clinical, theory, Alzheimer's and other dementias, CPR and designated areas of instruction; ~~theory and clinical instructors and approved evaluator, and whether the instruction is theory or clinical.~~

~~D)~~ ~~Curriculum Coordinator, for developmental disabilities aide training programs.~~

~~E)~~ Identification of approved evaluators; and

~~F)~~ Clinical site locations and signatures of the facility administrator or designee.

~~6)~~ ~~Resumes describing the education, experience, and qualifications of each program instructor including a copy of any valid Illinois licenses, as applicable.~~

7) Any clinical site agreements for the use of facilities and equipment that are not owned or operated by the program sponsor. Agreements ~~Such agreements~~ shall be signed by the owner or operator of the facilities or equipment and by the program sponsor. ~~shall include the dates such facilities or equipment will be used, and a description of the classrooms, laboratory, clinical training equipment, and any other facilities or equipment that will be used in the program.~~

8) A copy or a description of the evaluation tools that will be used to evaluate the following aspects of the training program:

A) Training program objectives, content and methodology; ~~and instructors.~~

B) Training program instructor; ~~content.~~

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- C) Student Clinical performance, encompassing all skills taught, and, for a BNATP Basic Nursing Assistant Training Program, the Department State-approved performance manual skills evaluation developed from the curriculum outlined in Section 395.300.
- i) Comprehensive final examination with answer key;
  - ii) Laboratory and clinical performance evaluation tools; and
  - iii) Clinical performance skills checklist.
- 9) A copy of the attendance policy.
- 10) A floor plan indicating (BNATP Only):
- A) Classroom and laboratory dimensions;
  - B) The placement of laboratory equipment, including the location of the hand-washing sink;
  - C) Student seating accommodations;
  - D) The location of audiovisual (AV) equipment; and
  - E) Adequate space to provide the training component and not interfere with the individuals' activities.
- 11) A statement identifying other businesses and entities operating at this location.
- c) The program sponsor for all programs except Direct Support Person Developmental Disabilities Aide Training Programs (or this type of program known by another name) shall submit the ~~letter of~~ application for approval of a training program to the Department or to DHS-DD at the ~~following~~ address provided on the application.;

Illinois Department of Public Health  
Office of Health Care Regulation  
Division of LTC Field Operations

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~~525 West Jefferson Street  
Springfield, Illinois 62761~~

- d) ~~No changes will be required in the program content of any training program, which was approved under rules in effect at the time of the adoption of amended rules, until a review by the Department indicates that revisions to the program content are needed to keep the program in compliance with the amended rules.~~
- d) ~~AGENCY NOTE:—~~The Department has a Memorandum of Understanding with the Department of Human Services for that agency to administer the approval of the ~~Direct Support Person~~~~Developmental Disabilities Aide~~ Training Programs (or this type of program known by another name) in accordance with the requirements of this Part. Questions concerning that type of program and ~~correspondence~~ should be directed to the Illinois Department of Human Services, ~~Division Office~~ of Developmental Disabilities, Bureau of Quality Management Human Resource Development, ~~319 East Madison, Suite 4J, Springfield, Illinois 62701.~~

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.120 Review Process and Program Approval**

- a) The Department or DHS-DD will evaluate the application and proposed program for conformance to the program requirements contained in this Part. Based on this review, the appropriate Department will take one of the following actions regarding the application:
- 1) Grant approval of the proposed program.
  - 2) ~~Grant approval of the proposed program contingent on the receipt of additional materials, or revisions, needed to remedy any minor deficiencies in the application or proposed program, which would not prevent the program from being implemented, such as deficiencies in the number of hours assigned to cover different areas of content, which can be corrected by submitting a revised schedule or outline.~~
  - ~~2)3)~~ Deny approval of the proposed program based on major deficiencies in the application ~~or proposed program, which would prevent the program from being implemented, such as deficiencies in the qualifications of instructors~~

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~~or missing areas of content.~~

- b) When the Department DHS-DD finds that a proposed program fails to comply with the program requirements contained in this Part or 42 CFR 483.151(b)(2)(i) ~~through- (v) (October 1, 1994, no further editions or amendments included)~~, the appropriate Department will notify the sponsor in writing ~~of the nature of the deficiencies~~, and ~~will~~ request additional or revised documentation ~~necessary materials, or revisions, needed~~ to remedy deficiencies in the application ~~or proposed program~~.
- c) When the Department ~~or DHS-DD~~ finds that a proposed program, along with any additional materials and revisions ~~that which~~ have been submitted, complies with the program requirements contained in this Part, the appropriate Department will issue a written notice of program approval to the program sponsor.
- d) The Department will issue an identification number to each approved BNATP training program sponsor. The sponsor shall reference that number in any correspondence to the Department about the program.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.130 Review of Approved Training Program**

- a) The Department ~~or DHS-DD~~ will review each approved training program for renewal at least every two year~~other year~~.
- b) The program renewal review shall evaluate compliance with this Part and include; ~~if necessary~~, an on-site monitoring visit, as appropriate.
- c) Determination of the need for additional on-site visits and other monitoring activities by the Department will be based upon (BNATP Only):
- 1) The proportion of an approved training program's students who successfully complete the training program; ~~will be considered by the Department in determining the need for additional on-site visits and other monitoring activities.~~
  - 2) The program's cluster scores summary reports;

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- 3) The nature of complaints that may warrant an investigation by the Department or by DHS-DD;
- 4) Submission of incorrect documentation; and
- 5) A review of noncompliance issues that resulted in probation or the suspension of program approval (see Section 395.190).

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.140 Inactive Status**

- a) The Department or DHS-DD shall place an approved training program on inactive status upon receipt of a written request from the program sponsor for placement on inactive status~~such action~~ or if there has been no program activity for 24 consecutive months~~during the last year~~.
- ~~b) To return an approved training program that has been on inactive status for one year or less to active status, the sponsor of the program shall submit a written request to the Department detailing any changes in the approved training program and a master schedule in accordance with Section 395.110(b)(5) of this Part.~~
- ~~b)e) To apply for a return to active status, an~~ approved training program that has been on inactive status ~~for more than one year~~ shall submit an application and materials~~a letter of application~~ as required in Section 395.110 ~~of this Part~~.
- ~~c)d) The request for return to active status shall~~must be submitted no fewer than 90~~60~~ days prior to the scheduled beginning of the program.
- ~~d) Based on a review of the application and materials for return to active status, the Department or DHS-DD will follow the requirements of Section 395.120.~~

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.150 Minimum Hours of Instruction**

- a) Time frames for Basic Nursing Assistant Training Programs
  - 1) Each program shall include a minimum of 120 hours of instruction, excluding breaks, meals, lunch, and any orientation to the program and

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~~clinical sitespecific policies of the employing facility.~~

- 2) The basic program content shall be presented in a minimum time frame of three weeks, but cannot exceed 120 days, unless the training program is conducted by a community college or other educational institution on a term, semester, or trimester basis.
  - 3) ~~The program shall include a minimum of 80 hours of theory instruction and 40 hours of clinical instruction. There shall be a ratio of two hours of theory, including supervised laboratory, to each hour of supervised clinical practice instruction (i.e., 80 hours of theory and 40 hours of clinical). This ratio applies only to the required 120 hours of instruction.~~
  - 4) ~~The program shall include a~~ minimum of 12 hours of theory instruction related to Alzheimer's disease and ~~other related~~ dementias, as described in Section 395.300(i)(~~r~~) through (z), ~~shall be included in each program, excluding breaks, meals and clinical conferences. lunch, and any orientation to the specific policies of the employing facility.~~
  - 5) ~~The program shall include a minimum of four hours of theory instruction in CPR.~~
  - 6) ~~5) The program shall include a~~ minimum of 16 hours of training in the following areas, ~~which shall~~ must be conducted prior to any direct contact with a resident (42 CFR 483.152(b)(1)(a)(~~3-6~~)):
    - A) Communication and interpersonal skills;
    - B) Infection control;
    - C) Safety/emergency procedures, including airway obstruction clearing procedure~~the Heimlich maneuver~~;
    - D) Promoting residents' independence; and
    - E) Promoting residents' rights.
- b) Time frames for Direct Support Person~~Developmental Disabilities Aide Training Programs and Basic Child Care/Habilitation Aide~~ Training Programs

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- 1) Each program shall include a minimum of 120 hours of instruction, excluding breaks, ~~meals~~~~lunch~~, and any orientation to the specific policies of the employing facility.
  - 2) The basic program content shall be presented in a minimum time frame of three weeks, but cannot exceed 120 days, unless the training program is conducted by a community college or other educational institution on a term, semester, or trimester basis.
  - 3) ~~Training shall consist of 40 hours of approved classroom instruction and at least 80 hours of approved on-the-job training. There shall be a ratio of one hour of theory, including supervised laboratory with the theory instructor, for every two hours of clinical practice instruction (on-the-job training). This ratio applies only to the minimum required 120 hours of instruction.~~
- c) Time frame requirements for Psychiatric Rehabilitation Services Aide Training Programs
- 1) Each program shall include a minimum of 120 hours of instruction, excluding breaks, ~~meals~~~~lunch~~, and any orientation to the specific policies of the employing facility.
  - 2) The basic program content shall be presented in a minimum time frame of three weeks, but cannot exceed 120 days.
  - 3) For the Health Care Skills Module only, there shall be a ratio of three hours of theory, including supervised laboratory instruction, to each hour of supervised clinical practice instruction. The other two modules ~~shall~~will consist of theory and supervised laboratory instruction.
  - 4) A waived program may contain fewer than 120 hours if all students are individuals who have satisfactorily completed an Illinois approved BNATP~~Basic Nursing Assistant Training Program~~, and have at least one year of experience in the last three years working as a nursing assistant with persons with mental illness.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

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**Section 395.155 Train the Trainer Program (BNATP Only)**

- a) Requirements for Basic Nursing Assistant Instructor Train the Trainer Programs
- 1) Each Train the Trainer program shall be college based, and the college shall have an active, approved BNATP.
  - 2) The Train the Trainer program shall include the Alzheimer's component and may include an Approved Evaluator Workshop.
  - 3) The college shall submit an application for program approval to the Department at least 90 days prior to the scheduled start date of the initial Train the Trainer Course.
  - 4) The application shall include, at a minimum, the following documentation:
    - A) A program summary, including the philosophy and purpose of the program;
    - B) A statement that the Department's model program based on Section 395.156 is being used;
    - C) An outline of the number of hours that will be dedicated to each component of the training program, with no fewer than 31 total hours, excluding breaks and meals;
    - D) A schedule of any modification to the model program presentation sequence;
    - E) A course syllabus, including the minimum required assignments;
    - F) A resume describing the education, experience and qualifications of the instructor;
    - G) The method used to inform program participants of the qualifications required to become a Department-approved instructor teaching any portion of a BNATP;

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- H) A sample of the certificate of completion that will be provided to participants who have successfully completed the Train the Trainer program or an independent course for Alzheimer's.
- b) Upon review of the required documentation described in this Section, the Department will:
- 1) Request additional information, if needed;
  - 2) Mail an approval letter, including a Train the Trainer program number, to the program sponsor; or
  - 3) Mail a denial letter, stating the reasons for the denial, to the program sponsor.
- c) Subsequent Train the Trainer program schedules shall be submitted in writing to the Department 30 days prior to start of the course.
- d) An official class roster shall be submitted to the Department within 10 working days after course completion.
- e) Any changes to course sequence shall be submitted to the Department within 30 days prior to the course's scheduled start date.
- f) An approved Train the Trainer instructor shall meet the following requirements:
- 1) Be a Department-approved instructor (pursuant to Section 395.160) for theory, clinical and Alzheimer's, and an Approved Evaluator for the BNATP;
  - 2) Have four years of documented teaching experience within the last six years, two of which shall be as a theory instructor in a BNATP; and
  - 3) Have completed Department approved instructor training.

(Source: Added at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.156 Train the Trainer Model Program (BNATP Only)**

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The Train the Trainer Model program shall include, at a minimum, the following curriculum:

- a) Module I – Course Contract
  - 1) Importance of contracts. Objectives: upon completion of this unit, the participant will be able to:
    - A) Articulate the importance of various contracts in defining course parameters, including a syllabus, clinical contracts and cooperative agreements;
    - B) Discuss the importance of developing a mission and philosophy statement;
    - C) Explore instructor and student expectations in a BNATP;
    - D) Identify various legal issues related to course contracts, confidentiality of student instructor progress, and record keeping; and
    - E) Examine methods of the documentation of student and instructor understanding of the course contract.
  - 2) Course description. Objective: upon completion of this unit, the participant will be able to discuss examples of course descriptions.
  - 3) Course schedule. Objectives: upon completion of this unit, the participant will be able to:
    - A) Identify considerations made when developing a course schedule;
    - B) Identify methods used to communicate the course schedule to students; and
    - C) Review a sample Master Schedule.
  - 4) Code of conduct. Objectives: upon completion of this unit, the participant will be able to:

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- A) Discuss aspects related to a CNA course code of conduct in both classroom and clinical environments;
  - B) Explore the components of an appearance/dress code; and
  - C) Describe the protocols needed to address student safety issues.
- 5) Attendance. Objectives: upon completion of this unit, the participant will be able to explain student guidelines related to:
- A) Attendance requirements;
  - B) Notification;
  - C) Make-up policy; and
  - D) Mandatory content.
- 6) Health requirements. Objective: upon completion of this unit, the participant will be able to identify the following required student health information:
- A) Physical examination;
  - B) Tuberculosis tests;
  - C) Hepatitis B;
  - D) Pregnancy; and
  - E) Restrictions.
- 7) Evaluation methods. Objective: upon completion of this unit, the participant will be able to integrate appropriate evaluation methods related to:
- A) Grading policy;
  - B) Laboratory skills; and

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- C) Clinical skills.
- 8) Assignments. Objective: upon completion of this unit, the participant will be able to discuss the development of course assignments related to:
  - A) Theory; and
  - B) Clinical instruction.
- 9) Special needs. Objectives: upon completion of this unit, the participant will be able to identify special needs arrangements for students with disabilities. These arrangements include the following:
  - A) Tutoring;
  - B) Study partner; and
  - C) Americans With Disabilities Act requirements related to program policies and reasonable accommodations.
- b) Module Two – Dynamics of Teaching
  - 1) Principles of teaching. Objective: upon completion of this unit, the participant will have examined current teaching theories.
  - 2) Principles of learning. Objective: upon completion of this unit, the participant will be able to demonstrate understanding of current learning theories.
  - 3) Learning styles. Objectives: upon completion of this unit, the participant will be able to compare and contrast various learning styles, which include:
    - A) Visual;
    - B) Auditory;
    - C) Tactile;

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- D) Kinetic; and
- E) Combination of styles.
- 4) Influences. Objectives: upon completion of this unit, the participant will be able to identify influences on the learner's educational experience, which include the following:
  - A) Culture;
  - B) Socio-economics; and
  - C) Age.
- c) Module Three: Course Development
  - 1) Behavioral learning objectives. Objective: upon completion of this unit, the participant will be able to develop measurable behavioral learning objectives.
  - 2) Curriculum development. Objectives: upon completion of this unit, the participant will be able to:
    - A) Compile a curriculum development plan, including mandatory content and task analysis;
    - B) Discuss the implementation of the Department's Model BNAT curriculum (see Section 395.300); and
    - C) Interpret the Department's curriculum/task list matrix.
  - 3) Ethical/legal use. Objectives: upon completion of this unit, the participant will be able to discuss the ethical concerns and legal issues in regard to:
    - A) Plagiarism; and
    - B) Copyright infringement.

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- 4) Evaluative methods. Objectives: upon completion of this unit, the participant will be able to:
- A) Compare and contrast various formats of written tests, which include, but are not limited to:
    - i) Multiple choice;
    - ii) True and false;
    - iii) Essay;
    - iv) Matching; and
    - v) Fill in the blank;
  - B) Discuss knowledge-based versus application-based testing;
  - C) Identify appropriate methods of skills testing;
  - D) Explore the use of test banks;
  - E) Identify internal or external tools used to perform program assessment. External tools may include, but are not limited to:
    - i) Program cluster summary report;
    - ii) Curriculum/task list matrix report; and
    - iii) Monthly program report.
- 5) Clinical instruction. Objectives: upon completion of this unit, the participant will be able to complete the following:
- A) Summarize components of a pre- and post-conference;
  - B) Describe methods of student supervision during a clinical rotation in regard to observing and guiding;

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- C) Choose techniques to enhance communication;
  - D) Identify documentation performed by a clinical instructor; and
  - E) Recognize the processes surrounding textbooks, which include reviewing, selecting and ordering.
- d) Module Four: Methodologies
- 1) Content delivery methods. Objectives: upon completion of this unit, the participant will be able to integrate a variety of teaching techniques into the curriculum, which may include, but are not limited to:
    - A) Lecture;
    - B) Discussion;
    - C) PowerPoint;
    - D) Handouts; and
    - E) Study guide.
  - 2) Classroom activities. Objectives: upon completion of this unit, the participant will be able to organize appropriate classroom learning activities such as:
    - A) Icebreakers;
    - B) Groups;
    - C) Games;
    - D) Case scenario;
    - E) Projects/paper;
    - F) Worksheets;

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- G) Puzzles;
  - H) Skits;
  - I) Role-playing; and
  - J) Skills demonstrations.
- 3) Technology use. Objective: upon completion of this unit, the participant will be able to select appropriate audiovisual or other equipment for use in the course such as:
- A) Overhead projection;
  - B) Document camera;
  - C) CD-Rom;
  - D) DVD; and
  - E) Internet.
- e) Module Five: Sample Content Areas
- 1) Rehabilitation/restorative care. Objectives: upon completion of this unit, the participant will be able to:
    - A) Explain the philosophy surrounding rehabilitation/restorative care;
    - B) Describe basic needs of the person involved in the rehabilitation/restorative care process;
    - C) Identify adaptive equipment that can be used for the person involved in the process.
  - 2) Communication. Objectives: upon the completion of this unit, the participant will be able to:

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- A) Describe the five principles of effective communication;
  - B) Discuss types of communication;
  - C) Identify methods of effective communication;
  - D) Explain the common barriers to effective communication; and
  - E) Articulate various topics related to communication to include in the BNATP curriculum.
- 3) Current issues/stressors. Objectives: upon the completion of this unit, the participant will be able to:
- A) Identify common perceptions of CNAs and their role;
  - B) Explore common interpersonal conflicts experienced by CNAs in the workplace;
  - C) Identify methods to cope with the stress related to being short staffed; and
  - D) Recognize issues related to CNAs prioritizing resident care.
- f) Module Six: Teaching Demonstrations
- 1) Demonstration guidelines. Objective: upon completion of this unit, the participant will be able to articulate guidelines for preparing a teaching demonstration.
  - 2) Lesson plan. Objective: upon completion of this unit, the participant will be able to compile a lesson plan using a four-step criteria.
  - 3) Test questions. Objective: upon completion of this unit, the participant will be able to write five appropriate test questions with rationales that correspond to the teaching simulation material.

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- 4) Individual teaching demonstration. Objective: upon completion of this unit, the participant will be able to perform an individual teaching demonstration.
  - 5) Analysis/critique. Objective: upon completion of this unit, the participant will be able to analyze teaching simulations through the use of verbal/written critiques.
- g) Module Seven: Alzheimer's Disease (may be offered independently)
- 1) Description. Objective: upon completion of this unit, the participant will be able to provide an overview of Alzheimer's Disease and related disorders.
  - 2) Stages. Objectives: upon completion of this unit, the participant will be able to identify the following stages of Alzheimer's Disease:
    - A) Early;
    - B) Middle;
    - C) Late; and
    - D) Terminal.
  - 3) Common behaviors and interventions. Objectives: upon completion of this unit, the participant will be able to describe common behaviors of the person with Alzheimer's Disease and interventions used for specific behaviors, including, but not limited to, the following:
    - A) Rummaging;
    - B) Wandering;
    - C) Clinging;
    - D) Delusions;
    - E) Hallucinations;

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- F) Agitation;
  - G) Combativeness;
  - H) Sundowning;
  - I) Catastrophic reactions; and
  - J) Sexually inappropriate behavior.
- h) Module Eight: Approved Evaluator Workshop (may be offered independently and shall be presented only by Department staff or designee)
- 1) Federal regulation. Objectives: upon completion of this unit, the participant will be able to discuss federal laws and regulations that have an impact on the BNATP, which include, but are not limited to:
    - A) Omnibus Budget Reconciliation Act of 1987 (OBRA); and
    - B) Code of Federal Regulations (42 CFR 483.151, 42 CFR 483.152 and 42 CFR 483.156).
  - 2) State regulation. Objectives: upon completion of this unit, the participant will be able to:
    - A) Identify Illinois administrative rules that govern an approved BNATP;
    - B) Describe the methods necessary to meet State requirements related to the Health Care Worker Background Check Act and Health Care Worker Background Check Code;
    - C) Assemble the forms required when conducting an approved BNATP in order to maintain compliance; and
    - D) Establish a plan for communicating information to the Department.

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- 3) State competency testing. Objective: upon completion of this unit, the participant will be able to describe the methods necessary to ensure student competency testing in Illinois.
- 4) Relevant websites. Objective: upon completion of this unit, the participant will be able to navigate websites relevant to a BNATP.
- 5) Approved evaluator. Objectives: upon completion of this unit, the participant will be able to:
  - A) Discuss the role and responsibilities of an Approved Evaluator; and
  - B) Explain the performance skills evaluation procedure.
- 6) Manual skills evaluation. Objective: upon completion of this unit, the participant will be able to demonstrate competence in the required performance skills according to the established standards and guidelines.

(Source: Added at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.160 Instructor Requirements**

- a) Requirements for Clinical and Theory Instructors in a BNATP Basic Nursing Assistant Program or a Basic Child Care/Habilitation Aide Training Program
  - 1) The Department will evaluate each~~Each course~~ instructor shall be for minimum requirements set forth in this Section and will approve or deny approval of the instructor before the instructor provides program instruction. The program coordinator shall submit a request for instructor approval 60 days prior to the first day of the course. ~~a registered nurse with a minimum of two years nursing experience, who has no other duties while engaged in the training program. Instructors shall be required to have one year of experience as a registered nurse in one or both of the following areas:~~
  - 2) Each theory and clinical instructor shall:
    - A) Be a registered nurse with a minimum of two years of nursing

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experience;

- B) Have no other duties while engaged in the training program;
  - C) Have successfully completed a Department-sponsored Approved Evaluator Workshop prior to initial approval and complete a Department-sponsored Approved Evaluator Workshop refresher course every five years thereafter;
  - D) Have one year of experience as a registered nurse in one or both of the following areas:
    - i) ~~A)~~ Teaching theory in an accredited nurse~~nurse's~~ training program; or;
    - ii) ~~B)~~ Providing nursing care, including personal care and activities of daily living, to older adults~~Caring for the elderly or for the chronically ill adult~~of any age through employment in a nursing facility, extended care unit, geriatrics department, chronic care unit, hospice, swing bed unit of a hospital, or other long term care setting.
- 3) Only approved clinical and approved theory instructors shall be used.
- 4) ~~2)~~ Each theory course instructor and each clinical instructor shall have completed a Department-approved Train the Trainer program. ~~also possess at least one of the following qualifications:~~
- A) ~~A valid Illinois teaching certificate (or a provisional certificate).~~
  - B) ~~A certificate indicating completion of a Department approved train the trainer workshop/program.~~
  - C) ~~Evidence of at least one semester of formal teaching experience.~~
  - D) ~~College coursework during the previous six years, which includes at least one course in teaching/learning principles, curriculum development, teaching methods, or instructional techniques.~~

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- 5) Each theory instructor and each clinical instructor shall complete a Department-approved Train the Trainer review program every five years.
- b) Requirements for Instructors of the Alzheimer's Disease and Related Dementias (Section 395.300~~(i)-(r)~~ through ~~(z)~~) portions~~Portions~~ of a BNATP ~~Basic Nursing Assistant Program~~
- 1) Each instructor shall meet the Clinical Instructor requirements in subsection (a). ~~Each instructor shall be a registered nurse, who has no other duties while engaged in the training program.~~
- 2) Each instructor shall also provide documentation of completion of a Department-approved specialized workshop, course, seminar or other approved training for instruction in Alzheimer's Disease and related dementias. ~~possess at least one of the following qualifications:~~
- A) ~~At least one year of experience providing services for patients with Alzheimer's disease and related dementias and at least one semester of formal teaching experience.~~
- B) ~~Documentation of completion of a specialized workshop, course, seminar or other training for instruction in Alzheimer's disease and related dementias.~~
- c) Requirements for Instructors in a Direct Support Person ~~Developmental Disabilities Aide~~ Training Program
- 1) The course~~curriculum~~ coordinator shall monitor~~monitors~~ the Direct Support Person Training Program and shall ensure Developmental Disabilities Aide Training Program and ensures that instructors are qualified and are instructing the program as required, and that the required documentation is maintained.
- 2) Each classroom~~program~~ instructor ~~of theory~~ shall meet at least one of the following requirements:
- A) Be a QIDP ~~Qualified Mental Retardation Professional~~ with at least one year of experience with developmental disabilities programs and who has successfully completed a DHS-approved QIDP

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Orientation Training Program;

- B) Have a valid Illinois teaching certificate with at least one year of experience with developmental disabilities programs;
  - C) Be a community college or college instructor with at least one year of teaching experience and familiarization with developmental disabilities programs; or
  - D) Be a special content instructor with at least one year of experience in his or her field of expertise and with at least one year of experience working with individuals with developmental disabilities. ~~Be a registered nurse with at least one year of experience with developmental disabilities programs.~~
- d) Requirements for Instructors in a Psychiatric Rehabilitation Services Aide Training Program
- 1) Each program instructor shall meet the clinical instructor requirements in subsection (a) submit verification of successful completion of a train the trainer workshop, for each module taught, approved by the Department of Human Services' Division~~Office~~ of Mental Health.
  - 2) Instructors for the Introduction to Mental Illness and Psychiatric Rehabilitation Module and the Psychiatric Rehabilitation Skills Module shall either:
    - A) Be a community college or college instructor with at least one year of teaching experience and familiarization with programs for individuals with serious mental illness; or
    - B) Have a bachelor's degree in a mental health-related field or be a certified psychiatric nurse and have at least three years of experience providing services to persons with serious mental illness.
  - 3) Instructors for the Health Care Skills Module shall be a registered nurse with a minimum of two years of nursing experience. Instructors shall be required to have one year of experience as a registered nurse in one or

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both of the following areas:

- A) Teaching an accredited nurse training program;
  - B) Caring for persons with serious mental illness through employment in a residential setting.
- e) ~~Supplemental Instructors (A Special Content Instructor) in a BNATP Basic Nursing Assistant Program and Direct Support Person Program shall~~ Developmental Disabilities Aide Program must have at least one year experience in ~~his or her field~~ their fields of expertise. These would include, but not be limited to, registered nurses, Qualified Intellectual Disabilities Professionals, licensed practical nurses, pharmacists, dieticians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physical and occupational therapists, activities specialists, speech/language/hearing therapists, and resident rights experts. (See 42 CFR 483.152(a)(5)(iv).)
- f) Only Department- or DHS-DD-approved CPR instruction may be used. A CPR instructor shall provide current documentation of training at the health care provider level or health care provider instructor level from a nationally recognized program. Documentation of current CPR certification at this level shall be maintained and provided to the Department or DHS-DD.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.162 Approved Evaluator (BNATP Only)**

- a) Requirements for an Approved Evaluator and an Approved Outside Evaluator
  - 1) Shall be an approved clinical instructor and meet the requirements in Section 395.160(a); and
  - 2) Shall have successfully completed a Department-sponsored Approved Evaluator Workshop prior to initial approval and completed a Department-sponsored Approved Evaluator Workshop refresher course every five years thereafter.

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- b) For a facility-based BNATP, the program's Clinical Instructor/Approved Evaluator shall determine competencies on all approved performance skills. Selected performance skills as determined by the Department shall then be evaluated by an Approved Outside Evaluator, who shall have no fiduciary connection, within 30 days before or after the evaluation, with the facility at which the student is employed or will be employed.
- c) An Approved Evaluator shall have the following responsibilities:
- 1) Evaluation of performance skills in conjunction with an approved BNATP;
  - 2) Evaluation of performance skills as an Approved Outside Evaluator for a facility-based program; and
  - 3) Evaluation of performance skills as part of the CNA recertification process.

(Source: Added at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.165 Program Coordinator (BNATP Only)**

- a) Requirements for Program Coordinators of a BNATP – only an approved program coordinator shall be used.
- b) A Program Coordinator of a BNATP shall be a registered nurse and shall have the following responsibilities:
- 1) Planning, implementing, evaluating and coordinating a BNATP as required in this Part;
  - 2) Planning, implementing, evaluating and coordinating competency testing submission;
  - 3) Planning, implementing, evaluating and coordinating criminal background check submission;
  - 4) Completing, verifying and submitting accurate documentation as required in this Part;

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- 5) Functioning as the primary contact in communications with the Department;
- 6) Formulating, implementing and communicating corrective measures as required by the Department; and
- 7) Notifying the Department, in writing and within five business days, after a change in program coordinator.

(Source: Added at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.170 Program Operation (BNATP Only)**

- a) ~~An educational entity, other than a secondary school, conducting a Nurse Aide Training Program shall initiate a UCIA criminal history records check in accordance with the requirements of the Health Care Worker Background Check Act [225 ILCS 46] prior to entry of an individual into the training program. A secondary school may initiate a UCIA Criminal History Record Check prior to the entry of an individual into a training program. (Section 3-206(a-0.5) of the Act)~~
- b) ~~For the purpose of this Section, "initiate" means the obtaining of the authorization for a record check from a student. The educational entity shall transmit all necessary information and fees to the Illinois State Police within 10 working days after receipt of the authorization. (Section 15(3) of the Health Care Worker Background Check Act) Authorization shall be requested on the first day of class.~~
- c) ~~The results of the criminal history record check shall be attached to the student's competency test application. If the student does not complete a test application or takes the competency test prior to receiving the results of the criminal history record check, the program shall submit the results to the Department. The program shall also provide the student with a copy of the results.~~
- d) ~~The program shall provide counseling to all individuals seeking admission to the program concerning the Health Care Worker Background Check Act. The counseling must include, at a minimum:~~
  - 1) ~~notification that a UCIA criminal history record check will be initiated in~~

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- ~~accordance with subsection (a) above;~~
- 2) ~~a clear statement that a UCIA Criminal Background Check is required for the individual to work as a nursing assistant, developmental disabilities aide, or basic child care/habilitation aide in Illinois; and~~
- 3) ~~a listing of those Sections of the Criminal Code of 1961 [720 ILCS 5], the Cannabis Control Act [720 ILCS 550], and the Illinois Controlled Substances Act [720 ILCS 570] for which a conviction would disqualify the individual from finding employment as a nursing assistant~~
- a)e) A master schedule shall be submitted to the Department 15 business days~~Ten working days~~ prior to the start of the actual training program, an updated master schedule, ~~in accordance with Section 395.110(b)(65) of this Part, shall be submitted to the Department.~~
- b)f) Any change in program content, objectives, or instructors shall be submitted to the Department at least 30~~thirty~~ days prior to program start date~~delivery~~.
- c) Unscheduled changes in the master schedule shall be promptly reported to the Department.
- d)g) A BNATP~~In the Basic Nursing Assistant Training Program, the program~~ shall require each student to show competency of Department-approved performance~~manual~~ skills by hands-on return demonstration. The performance~~manual~~ skills evaluation shall be conducted by an Approved Evaluator~~approved evaluator~~. If the program is facility-based, an Approved Outside Evaluator shall perform an additional evaluation of performance skills. ~~Approved evaluators employed by a facility may not evaluate students trained by the facility program. The facility shall assure that an approved evaluator who is not an approved instructor meets the requirements of Section 395.160 of this Part.~~
- e) The student-to-instructor ratio shall not exceed eight students per one clinical instructor and 15 students per one laboratory instructor.
- f) The BNATP shall provide access to medical equipment and supplies for student practice and demonstration of the required skills outlined in the model program.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

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**Section 395.171 Health Care Worker Background Check**

- a) A training program shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.
- b) The program shall provide counseling to all individuals seeking admission to the program concerning the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. The counseling shall include, at a minimum:
- 1) Notification that a fingerprint-based criminal history records check will be initiated;
  - 2) A clear statement that a fingerprint-based criminal history records check is required for the individual to work as a direct access worker, a CNA or a Direct Support Person in Illinois; and
  - 3) A listing of those offenses in Section 25 of the Health Care Worker Background Check Act for which a conviction would disqualify the individual from finding employment as a direct access worker, a CNA or a Direct Support Person unless the individual obtained a waiver pursuant to Section 40 of the Health Care Worker Background Check Act.

(Source: Added at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.173 Successful Completion of the Basic Nursing Assistant Training Program**

- a) A student shall be considered to have successfully completed the BNATP training program when he or she has: all of the following are met: The student has
- 1) Completed a minimum of completed at least 80 hours of theory and 40 hours of clinical instruction, including the required hours of content in accordance with Section 395.150; and;
  - 2) Demonstrated competence in the Department-approved performance manual skills.
- b) A student shall must pass the Department-established written competency

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examinationtest.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.174 Successful Completion of the Direct Support Person ~~Developmental Disabilities Aide or Basic Child Care/Habilitation Aide~~ Training Program**

A student shall be considered to have successfully completed the training program when he or she~~the student~~ has completed the classroom and on-the-job training requirements. The completion of training shall be reported to the Health Care Worker Registry~~theory and clinical instruction and tests/quizzes/exams in accordance with the sponsor's policies.~~

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.175 Program Notification Requirements (BNATP Only)**

The program sponsor shall submit, within 30 days after program completion, an official roster of all students~~a list of all trainees~~ who have successfully completed the training program. The official roster~~list~~ shall include, but not limited to, the following required information:

- a) Student identification, including name~~Name~~, complete home address and Social Security number~~of the trainee~~;
- b) Training program identification number~~Identification number of the training program~~;
- c) Program start and end dates~~completion date~~;
- d) Signature, or other verification as prescribed by the Department, of the Program Instructor and Approved Evaluator~~program instructor and approved evaluator~~, when appropriate, or Curriculum Coordinator~~curriculum coordinator~~, as applicable. (Any additional signatures are optional.)

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.190 Denial, Suspension, and Revocation of Program Approval (BNATP Only)**

- a) When the Department finds that a proposed program, along with any additional information and revisions that~~which~~ are submitted, fails to comply with the

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program requirements contained in this Part or 42 CFR 483.151(b)(2)(i) through - (v), the Department will notify the sponsor in writing of denial of program approval. The notice to the sponsor shall state the reasons for the denial and the right of the sponsor to appeal the denial and to a hearing before the Department.

- b) When the Department, upon evaluation or during monitoring, finds that an approved program does not comply with the program requirements contained in this Part or 42 CFR 483.151(b)(2)(i) through - (v), the Department will notify the sponsor in writing of the finding of non-compliance ~~of the program~~ and the reasons for the finding.

- 1) Findings of non-compliance include, but are not limited to:
  - A) The instructor is not approved by the Department;
  - B) The instructor does not meet the requirements of Section 395.160;
  - C) The program lacks an Approved Evaluator;
  - D) The program is not conducted in accordance with the master schedule;
  - E) The official roster of students is not submitted to the Department within 30 days after program completion;
  - F) The instruction does not follow the approved curriculum;
  - G) The instruction is being held at a location other than the approved site or sites;
  - H) The program does not satisfy the requirement of 120 hours of training;
  - D) The master schedule was not received within 15 days prior to the first scheduled class day;
  - J) The program exceeds the student-to-instructor ratio at the clinical site;

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- K) The program exceeds the student-to-instructor ratio in a laboratory setting;
- L) The laboratory environment does not meet requirements in Section 395.50;
- M) The theory instruction site does not meet student needs for space, comfort and learning; or
- N) There was no review of the approved training program pursuant to Section 395.130.
- 2) The BNATP shall submit a written plan of correction with completion dates to address all findings of non-compliance within 10 days following receipt of the Department's notification.
- 3) A BNATP found in non-compliance may be subject to follow-up monitoring by the Department if necessary to ensure correction.
- c) When the Department determines that the findings of non-compliance finds that any conditions stated in the written notice of non-compliance issued under subsection (b) of this Section have not been corrected within thirty days after the date of issuance of such notice, the Department will place the BNATP on probationary status~~revoke or suspend its approval of the program.~~
- 1) The Department will notify the BNATP in writing regarding probationary status, including conditions of probation and the duration of the probationary period~~shall suspend approval when the program fails to substantially comply with the approved program plan during the operation of the program. Substantial failure to comply with the approved program plan includes program instruction being conducted contrary to the master schedule, contrary to the approved content, by an individual other than the approved instructor, or at a location other than the approved site or sites.~~
- 2) When the Department determines that the findings of non-compliance in the written notice issued under subsection (b) have been corrected, the Department will remove the BNATP from probationary status.~~The Department will revoke approval when an approved program fails to comply with the program requirements of this Part or 42 CFR~~

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~~483.151(b)(2)(i-v).~~

- 3) The Department will notify the BNATP in writing when the probationary status has been lifted.
- d) When the Department determines that the findings of non-compliance in the written notice of probation issued under subsection (c) have not been corrected, the Department will suspend or revoke its approval of the program.
  - 1) The Department will notify the BNATP in writing regarding the suspension status, including the duration of suspension and conditions of reinstatement.
  - 2) A BNATP placed on suspension shall not conduct nursing assistant training programs until notified by the Department in writing.
  - 3) The Department will notify the BNATP in writing when the suspension has been lifted.
  - 4) A revoked BNATP shall not conduct nursing assistant training programs.
  - 5)3) When the approval of a program has been suspended or revoked for reasons other than 42 CFR 483.151(b)(2)(i) through ~~-(v)~~, the program sponsor shall have a right to appeal the suspension or revocation and to a hearing before the Department.
- e)d) When the approval of a program has been denied, suspended, or revoked, for reasons other than 42 CFR 483.151(b)(2)(i) through ~~-(v)~~, the program sponsor may submit a written appeal of the action and request for a hearing within 10 calendar~~ten~~ days after notification of the decision to deny, revoke or suspend approval.
- f)e) All hearings under this Part shall be conducted in accordance with the Department's Rules of Practice and Procedure in Administrative Hearings ~~(77 Ill. Adm. Code 100)~~.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

## SUBPART B: TRAINING PROGRAM CURRICULA REQUIREMENTS

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**Section 395.300 Basic Nursing Assistant Training Program**

The BNATP~~Basic Nursing Assistant Training Program~~ shall include, at a minimum, the following:

- a) Module I – Introduction to Health Care
  - 1) Functions of Health Care Organizations. Objectives: upon completion of this unit, the student will be able to:
    - A) Describe the purposes and services of health care facilities/agencies, which include, but are not limited to, the following health care settings:
      - i) Long-term care facilities;
      - ii) Hospitals;
      - iii) Rehabilitation facilities;
      - iv) Home health agencies; and
      - v) Hospice care.
    - B) Person-Directed Care Across All Settings. Objectives: upon completion of the unit, the student will be able to:
      - i) Explain the philosophy of person-directed care;
      - ii) Discuss the concepts of person-directed care, which are self-determination, individual needs, ability focused, person before task, individualized choices, relationship building, holistic focused, and spontaneous activities;
      - iii) Contrast person-directed care with task-centered care;
      - iv) Explain how the CNA can apply the concepts to provide person-directed care; and

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- v) Discuss the impact of a person-directed care model on those involved, including caregiver, elders and the health care facility.
- 2) The Interdisciplinary Team. Objectives: upon completion of this unit, the student will be able to:
- A) Discuss the purpose of the Interdisciplinary Team;
  - B) Describe ways to enhance the ability of the Interdisciplinary Team to accomplish its purpose;
  - C) Describe the role of each member of the Interdisciplinary Team;
  - D) Examine ways in which a CNA can become an effective team member; and
  - E) Discuss the crucial role of the CNA with the health care team.
- 3) The CNA Role Across Health Care Settings. Objectives: upon completion of this unit, the student will be able to:
- A) Demonstrate professional behaviors expected of a CNA in appearance and behaviors;
  - B) Describe work ethics for CNAs, including qualities, legal implications and ethical behaviors;
  - C) Identify competency standards in CNA practice, which include standardized testing and maintaining safety;
  - D) Discuss person-directed qualities by describing the attributes of:
    - i) An effective communicator and demonstrate effective interpersonal communication techniques;
    - ii) A resident advocate and describe methods to promote a resident's independence in decision making;



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Care Worker Background Check; and

- D) Develop awareness of resources to enhance career development for CNAs through CNA organizations, continuing education and career ladders.
- 5) Information Sharing. Objectives: upon completion of this unit, the student will be able to:
- A) Know frequently used medical terminology and abbreviations;
  - B) Describe the purpose and list components of the health care record;
  - C) Discuss pertinent information that should be reported to the nurse and give examples of observations that need to be reported immediately;
  - D) Know the legal aspects of recording in the health care record;
  - E) Discuss the requirements for recording in the health care record; and
  - F) Describe how the Interdisciplinary Team works together to develop an individualized plan of care:
    - i) Define the nursing process;
    - ii) Differentiate between the role of the CNA and the role of the nurse in the nursing process;
    - iii) List the steps of the nursing process;
    - iv) Differentiate between objective and subjective information; and
    - v) Discuss the role and the responsibilities of the CNA in reporting observations, developing a plan of care, and following the person's individualized plan of care.

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b) Module II – Rights and Relationships

- 1) Rights. Objectives: upon completion of this unit, the student will be able to:
  - A) Identify basic human rights;
  - B) Discuss the importance of State and federal regulations in promoting resident rights:
    - i) Describe the purpose of the Health Insurance Portability and Accountability Act (HIPAA);
    - ii) Explain the role of the CNA in ensuring compliance with HIPAA;
    - iii) Identify resident rights according to the Omnibus Budget Reconciliation Act of 1987 (OBRA);
    - iv) Discuss how following the State and federal regulations enhances the resident's quality of life;
    - v) Discuss how following the State and federal regulations enhances the resident's quality of care; and
    - vi) Describe the purpose of the Ombudsman Program (Older Americans Act);
  - C) Identify key concepts for person-directed care and discuss ways to apply the concepts for person-directed care:
    - i) Discuss the importance, principles and methods of building relationships with residents and family. The principles include, but are not limited to, trust, respect and commitment;
    - ii) Discuss methods for building relationships;
    - iii) Discuss ways to promote care partnerships;

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- iv) Discuss strategies the CNA can use to support a culture of home;
- v) Examine the CNA's role in promoting care partnerships;
- vi) Differentiate between care practices that are person-directed versus an institutional model; and
- vii) Discuss some of the limitations that the CNA may encounter focusing on person-directed care;
- D) Discuss the importance and describe the principles of culture competence:
  - i) Examine ways in which the culture of an elder may differ from the culture of the caregiver, such as generational, communication, family and religious differences, and differences in customs; and
  - ii) Recognize the impact of the CNA's views and values on the care provided;
- E) Discuss abuse, neglect and theft:
  - i) Describe the types of abuse, neglect and theft that occur in the health care setting;
  - ii) Discuss ways that elder abuse, neglect and theft can be prevented;
  - iii) Describe indications of abuse, neglect and theft;
  - iv) Explain the CNA's role in reporting elder abuse, neglect and theft;
  - v) Discuss requirements for reporting abuse, neglect and theft; and

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- vi) Discuss consequences of abusing, neglecting or stealing from a resident.
- 2) Holistic Care. Objectives: upon completion of this unit, the student will be able to:
- A) Explain the importance and describe the components of holistic care, which include, but are not limited to:
    - i) Physical;
    - ii) Social;
    - iii) Psychological; and
    - iv) Spiritual;
  - B) Discuss the culture of aging:
    - i) Describe the impact that physical changes may have on a person's self-image;
    - ii) Discuss the psychological effects of loss on the elder;
    - iii) Discuss the impact of aging on the family; and
    - iv) Describe how elders are viewed in society;
  - C) Describe ways in which the CNA can meet basic human needs of the elder and implement evidence-based practices to provide holistic care.
- 3) Communication. Objectives: upon completion of this unit, the student will be able to:
- A) List the components of communication;
  - B) Describe the principles of communication;

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- C) Identify the types of communication:
    - i) Distinguish between verbal and non-verbal communication; and
    - ii) Describe the appropriate use of touch in communication;
  - D) Identify effective techniques for enhancing communication, which include, but are not limited to:
    - i) Active listening;
    - ii) Focusing on feelings;
    - iii) Providing feedback;
    - iv) Observing non-verbal clues; and
    - v) Defusing anger;
  - E) Discuss barriers to the communication process, which include, but are not limited to:
    - i) Language;
    - ii) Culture;
    - iii) Perception; and
    - iv) Situation;
  - F) Discuss the CNA's responsibility for effective communication.
- 4) Interpersonal Relationships. Objectives: upon completion of this unit, the student will be able to:
- A) Describe professional boundaries in relationships with residents;
  - B) Discuss the importance of developing therapeutic relationships;

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- C) Discuss the importance of building relationships within the health care team; and
  - D) Describe appropriate relationship boundaries for a CNA as a member of the health care team.
- c) Module III – Infection Control in the Health Care Setting
- 1) Infection Control Issues. Objectives: upon completion of this unit, the student will be able to explain the following:
    - A) Microorganisms
      - i) List the different types of microorganisms;
      - ii) Differentiate between non-pathogens and pathogens;
      - iii) Describe the role normal flora play in resisting infection;
      - iv) Explain the importance of practicing asepsis in order to decrease a person's chance of developing a facility-acquired infection;
      - v) Identify common microbes that are drug resistant;
      - vi) Describe the implications of drug-resistant microbes; and
      - vii) List the requirements that microorganisms need for survival and growth;
    - B) Chain of infection
      - i) Explain the role that each link in the chain of infection plays in transmitting disease; and
      - ii) Identify factors that increase a person's risk of acquiring an infection;

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- C) Signs and symptoms of infection
- i) List and describe signs and symptoms of infection, which include, but are not limited to, pain, heat, redness, swelling and change in resident behavior; and
  - ii) List ways in which a CNA can prevent the spread of infection;
- D) Asepsis in health care
- i) Differentiate between clean and sterile techniques; and
  - ii) Describe principles for medical asepsis;
- E) State and federal regulations. Discuss the role of the CNA in meeting current State and federal regulations related to infection control in health care settings;
- F) Skills in hand hygiene
- i) Identify situations requiring hand hygiene techniques;
  - ii) Describe techniques for proper hand hygiene; and
  - iii) Demonstrate proper hand hygiene techniques;
- G) Skills in isolation techniques
- i) Discuss the impact of isolation on a person's well-being;
  - ii) Differentiate between standard precautions and transmission-based precautions;
  - iii) Contrast nursing care for persons with each category of transmission-based precautions;
  - iv) Demonstrate procedures according to established guidelines for Personal Protective Equipment (PPE);

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- v) Select the appropriate PPE for both standard and transmission-based precautions; and
  - vi) Demonstrate the procedure of removing PPE used in isolation.
- 2) Equipment and Supplies. Objectives: upon completion of this unit, the student will be able to:
- A) Discuss methods of disinfection;
  - B) Discuss methods of sterilization; and
  - C) Explain the role of the CNA in properly caring for equipment and supplies.
- d) Module IV – Emergency Procedures
- 1) Fire Safety. Objectives: upon completion of this unit, the student will be able to:
- A) List the three main types of fire:
    - i) Oil/grease;
    - ii) Electrical; and
    - iii) Paper/wood;
  - B) List the three elements necessary for a fire;
  - C) Describe risk factors for a fire, which include, but are not limited to:
    - i) Oxygen;
    - ii) Impaired cognition;



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- C) Explain the role of the CNA in relation to emergency preparedness.
- 3) Foreign Body Airway Obstruction. Objectives: upon completion of this unit, the student will be able to:
- A) Differentiate between partial airway obstruction and complete airway obstruction;
  - B) Demonstrate the procedures for dislodging a foreign body in:
    - i) A conscious victim; and
    - ii) An unconscious victim.
- 4) Incidents. Objectives: upon completion of this unit, the student will be able to:
- A) Identify the responsibility of the CNA when:
    - i) Assisting a resident who has fallen;
    - ii) A resident has eloped;
    - iii) A resident has sustained a thermal injury;
    - iv) A resident has a skin tear or bruise; and
    - v) A resident has ingested a harmful substance;
  - B) Identify the role of the CNA in providing psychosocial support after an incident/emergency.
- 5) State and Federal Regulations. Objective: upon completion of this unit, the student will be able to review current State and federal regulations pertaining to resident rights during an emergency.
- e) Module V – Injury Prevention in the Health Care Environment

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- 1) Risk Management. Objectives: upon completion of this unit, the student will be able to:
  - A) Explain and discuss State and federal regulations:
    - i) Explain the role of the CNA in meeting current State and federal regulations pertaining to injury;
    - ii) Discuss the role of the Occupational Safety and Health Administration (OSHA) in relation to injury prevention; and
    - iii) Explain the purpose of the Material Safety Data Sheets;
  - B) Explain and discuss ergonomics:
    - i) Explain the importance of ergonomics to the health care worker;
    - ii) Describe risk factors for the CNA that may contribute to injury;
    - iii) Demonstrate consistent use of body mechanics while providing care;
    - iv) Explain the principles of body mechanics;
    - v) Discuss techniques to ensure proper body mechanics; and
    - vi) Describe equipment to assist in promoting proper body mechanics.
- 2) Resident Safety. Objectives: upon completion of this unit, the student will be able to:
  - A) Discuss the importance of maintaining safety for the resident;
  - B) Identify factors in the elderly that contribute to an increased risk for injury;

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- C) Determine the CNA responsibility regarding each of the following safety issues:
- i) Falls;
  - ii) Elopement;
  - iii) Resident identification;
  - iv) Thermal injury;
  - v) Skin tears;
  - vi) Choking; and
  - vii) Poisoning;
- D) Explain and discuss restraint safety:
- i) Analyze the adverse psychological and physical effects of restraining a resident;
  - ii) Explain how to maintain resident's rights when a safety device or restraint must be applied;
  - iii) Discuss the legal implications of restraint usage;
  - iv) Discuss the right of a resident not to be restrained;
  - v) Discuss industry movement toward restraint-free environments;
  - vi) Explore the various alternatives to applying restraints;
  - vii) Demonstrate application of a less restrictive alternative;
  - viii) Recognize when a device is considered a restraint; and



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be able to:

- A) Describe various types of documentation required when safety infractions have occurred; and
- B) Discuss the responsibility of the CNA for documenting problems related to safety.

f) Module VI – Care of the Resident

1) Resident Living Space. Objectives: upon completion of this unit, the student will be able to:

A) Explain why a comfortable environment is important to a person's well-being;

B) Identify and discuss factors related to residential living space:

i) Identify the environmental factors that can affect a person's comfort in his or her living space; and

ii) Discuss the importance of personal belongings in the person's environment;

C) Explain and discuss the role of furniture and equipment in residential living space:

i) Discuss safety issues when operating a bed;

ii) Demonstrate how to operate a bed;

iii) Examine reasons for use of various bed positions;

iv) Demonstrate placing a hospital bed in various positions;

v) Explain how the over-bed table is used by the health care team and the resident;

vi) Demonstrate how to raise and lower the over-bed table;

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- vii) Describe how the bedside stand is used by the health care team and the resident;
  - viii) Explain why curtains and screening devices are important for the purposes of privacy;
  - ix) Identify the limitations of curtains and screening devices; and
  - x) Identify other equipment that is generally part of a resident's room;
- D) Explain the rules for proper maintenance of the resident's living space;
- E) Explain and discuss call system devices:
- i) Demonstrate prompt response to signal lights or call system devices;
  - ii) Explain various types of call systems; and
  - iii) Discuss use of alternatives if a call system fails;
- F) Explain and discuss bed making:
- i) Explain the importance of bed making for the person's comfort and well-being, encouraging personal preferences, and identifying the person's preferences when handling personal linens;
  - ii) Explain and demonstrate aseptic techniques when handling linens;
  - iii) Discuss the guidelines for making beds;
  - iv) Explain the difference between an unoccupied and occupied bed; and

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- v) Demonstrate making a closed bed an open bed and an occupied bed, according to established standards;
- G) Examine the importance of frequent observations of the resident in his/her living space, including, but not limited to:
  - i) Side rails;
  - ii) Bed position;
  - iii) Call light;
  - iv) Safety alarms;
  - v) Personal items;
  - vi) Linens; and
  - vii) Personal preferences;
- H) Demonstrate consistent maintenance of resident's comfort and safety.
- 2) Admission, Transfer, Discharge. Objectives: upon completion of this unit, the student will be able to:
  - A) Discuss admission procedures:
    - i) Compare and contrast admission to various types of health care settings;
    - ii) Discuss the emotional responses a person may experience when admitted to a health care facility;
    - iii) Identify the equipment needed to admit a person;
    - iv) Describe the process for admitting a person to the facility; and

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- v) Recognize the CNA's role in the care of a person being admitted;
- B) Discuss room transfers:
  - i) Identify the need for room transfers;
  - ii) Discuss the emotional responses that a person may experience when transferred to a different room;
  - iii) Describe the process used to transfer a resident from one room to another;
  - iv) Recognize the CNA's role in the care of a person transferring to a different room; and
  - v) Discuss the strategies the CNA uses to support a smooth transition to another room;
- C) Discuss discharge procedures:
  - i) Identify places to which a person may be discharged;
  - ii) Discuss the emotional responses a person may experience when being discharged to various facilities;
  - iii) Describe the process for discharging a resident; and
  - iv) Recognize the CNA's role in the care of the person being discharged;
- D) Demonstrate skills: height, weight:
  - i) Identify the purpose of obtaining height and weight measurements; and
  - ii) Demonstrate obtaining a person's height and weight measurements according to established standards.

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- 3) Psychosocial Concerns. Objectives: upon completion of this unit, the student will be able to:
- A) Explain the importance of recognizing psychosocial concerns;
  - B) Discuss psychosocial concerns common to residents;
  - C) Describe common behaviors associated with how a person is feeling;
  - D) Recognize the CNA's role in meeting the resident's psychosocial needs, which include:
    - i) Person-directed strategies;
    - ii) Observations;
    - iii) Documentation; and
    - iv) Reporting.
- 4) Promoting Resident Comfort and Managing Pain. Objectives: upon completion of this unit, the student will be able to:
- A) Recognize indicators that a resident is not comfortable and the CNA's role in maintaining a person's comfort, which includes:
    - i) Person-directed strategies;
    - ii) Observations;
    - iii) Documentation; and
    - iv) Reporting;
  - B) Discuss the importance of identifying when a person is experiencing pain:

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- i) Recognize indicators of a person experiencing pain;
  - ii) Compare various methods used for pain level evaluation;
  - iii) Examine non-pharmacological methods a CNA may use to assist a person in managing pain, which may include massage, imagery, relaxation technique, music or pet therapy;
  - iv) Recognize the CNA's role in caring for a person experiencing pain, which includes person-directed strategies, observations, documentation and reporting.
- 5) Body Structure. Objectives: upon completion of this unit, the student will be able to explain the organization of the human body, including cells, tissue, organs and systems.
- 6) Integumentary System. Objectives: upon completion of this unit, the student will be able to:
  - A) Identify the structures of the integumentary system;
  - B) Identify the functions of the integumentary system;
  - C) Discuss how changes in the skin may affect a person's life physically, psychologically and socially;
  - D) Discuss healthy skin:
    - i) Discuss the importance of maintaining healthy skin;
    - ii) Describe factors affecting the maintenance of healthy skin; and
    - iii) Recognize the CNA's role in promoting healthy skin;
  - E) Discuss common health concerns:
    - i) Identify various skin conditions, such as too moist, too dry,

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poor skin turgor, alterations in color, fragility and allergic reactions;

ii) Discuss common communicable diseases affecting the skin, such as shingles, scabies, fungal infections and pediculosis; and

iii) Discuss common injuries to the skin and examine various methods to prevent injuries, which include, but are not limited to, skin tears, contusions and burns;

F) Discuss pressure ulcers:

i) Identify the persons at risk for developing pressure ulcers;

ii) Identify the stages of pressure ulcers;

iii) List the sites where pressure ulcers are likely to develop;

iv) List the causes of pressure ulcers;

v) Explain interventions the CNA can take to prevent pressure ulcers;

vi) Describe various treatments for pressure ulcers; and

vii) Examine various actions taken by the CNA to care for the person with skin abnormalities;

G) Recognize the CNA's role in preventing pressure ulcers, which includes:

i) Person-directed strategies;

ii) Observations;

iii) Documentation; and

iv) Reporting;

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- H) Explain and demonstrate oral hygiene skills:
- i) Explain why oral hygiene helps meet the person's basic needs;
  - ii) Identify the supplies needed for oral hygiene;
  - iii) Demonstrate how to assist the person to brush his/her teeth, according to established standards;
  - iv) Demonstrate how to brush a person's teeth according to established standards;
  - v) Describe how to floss a person's teeth according to established standards;
  - vi) Describe special measures a CNA needs to practice when handling dentures;
  - vii) Demonstrate cleaning of dentures, according to established standards;
  - viii) Demonstrate insertion of dentures;
  - ix) Demonstrate removal of dentures;
  - x) Describe the special measures that need to be taken when providing mouth care for the unconscious resident;
  - xi) Explain when mouth care should be given to the unconscious resident;
  - xii) Describe how to perform mouth care on an unconscious resident, according to established standards; and
  - xiii) Recognize the CNA's role when providing oral hygiene;
- I) Discuss bathing skills:

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- i) Explain why bathing is important for meeting basic needs;
  - ii) Identify the factors that influence the bathing method chosen by a person and the health care team;
  - iii) Discuss the bathing schedule;
  - iv) Compare various types of skin care products;
  - v) Recognize the CNA's role in the application of skin care products;
  - vi) Describe the procedural steps for various types of bathing, such as complete bed bath, partial bath, tub bath and shower;
  - vii) Perform a complete bed bath, according to established standards;
  - viii) Demonstrate giving a partial bed bath, according to established standards;
  - ix) Explain procedures used when assisting a person to take a tub bath, according to established standards;
  - x) Demonstrate procedures used when assisting a person to take a shower, according to established standards;
  - xi) Discuss alternatives to traditional bathing methods; and
  - xii) Recognize the CNA's role in bathing the resident;
- J) Discuss and identify back massage skills:
- i) Identify the purpose of a back massage; and
  - ii) Demonstrate a back massage, according to established standards;

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- K) Explain and discuss perineal care skills:
- i) Explain the purpose of perineal care;
  - ii) Discuss the indications for perineal care;
  - iii) Demonstrate female and male perineal care according to established standards; and
  - iv) Recognize the role of the CNA in providing perineal care;
- L) Identify and demonstrate hair care skills:
- i) Identify the importance of providing hair care;
  - ii) Demonstrate brushing and combing hair, according to established standards;
  - iii) Explain various methods of shampooing hair; and
  - iv) Recognize the CNA's role in providing hair care;
- M) Explain and demonstrate shaving skills:
- i) Explain the importance of shaving as it relates to meeting basic needs;
  - ii) Demonstrate a shave, according to established standards; and
  - iii) Recognize the CNA's role in shaving a resident;
- N) Explain and demonstrate nail care skills:
- i) Identify the importance of nail care;
  - ii) Discuss nail care, for a person with special conditions, such as diabetes, impaired circulation and fungus;

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- iii) Demonstrate nail care, according to established standards;
  - iv) Differentiate between nail care for hands and feet; and
  - v) Recognize the CNA's role in providing nail care to the resident;
- O) Explain and demonstrate dressing and undressing skills:
- i) Identify the importance of being appropriately dressed;
  - ii) Demonstrate dressing and undressing a person, according to established standards;
  - iii) Describe special considerations, such as physical limitation, medical equipment, and special needs in dressing and undressing;
  - iv) Discuss the impact of appropriate dress on a person's quality of life and comfort; and
  - v) Recognize the CNA's role in dressing and undressing a resident;
- P) Discuss therapeutic applications:
- i) Identify various types of applications;
  - ii) Compare and contrast moist and dry applications;
  - iii) Explain the purpose and principles involved in the application of heat;
  - iv) Describe the effects of heat applications;
  - v) Explain the purpose and principles involved in the application of cold;

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- vi) Describe the effects of cold applications;
  - vii) Describe the procedure used for various applications;
  - viii) Identify a person at risk for complications associated with various applications; and
  - ix) Recognize the CNA's role in caring for a person receiving therapeutic application.
- 7) Musculoskeletal System. Objectives: upon completion of this unit, the student will be able to:
- A) Describe the structures of the musculoskeletal system, including the following:
    - i) The types of bones;
    - ii) The function and types of joints;
    - iii) The major functions of muscles; and
    - iv) The types of muscles;
  - B) Describe the functions of the musculoskeletal system;
  - C) Discuss how age-related changes in the musculoskeletal system may affect a person's life physically, psychologically and socially;
  - D) Identify the complications of immobility, including, but not limited to, contractures and atrophy;
  - E) Explain the importance of preventing complications of immobility and identify interventions to prevent these complications;
  - F) Identify common health concerns:
    - i) Arthritis. Identify types of arthritis and recognize the CNA's role in caring for a person with arthritis, such as

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person-directed strategies, observations, documentation and reporting;

ii) Fractures. Identify types of fractures and describe common causes of fractures, including osteoporosis; recognize the CNA's role in caring for a person in a cast or in traction, or who has had a hip fracture or hip replacement;

iii) Amputation. Identify common causes of amputation and describe the impact of an amputation on a person's life. Recognize the CNA's role in caring for a person with an amputation;

G) Discuss range of motion exercise skills:

i) Identify the purpose of range of motion;

ii) Explain the safety and comfort guidelines for range of motion exercises;

iii) Identify types of range of motion exercises, including active, passive and active-assistive;

iv) Describe and demonstrate the movements of range of motion exercise, which include abduction, adduction, extension, flexion, plantar flexion, dorsi-flexion, opposition, internal rotation, external rotation, pronation and supination; and

v) Recognize the CNA's role in performing range of motion exercises;

H) Discuss prosthetic and orthotic devices skills:

i) Identify the purpose of prosthetic and orthotic devices;

ii) Describe the types of prosthetic and orthotic devices; and

iii) Describe how to apply and remove various prosthetic and

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orthotic devices;

- I) Discuss lifting and moving skills:
  - i) Identify the principles of lifting and moving;
  - ii) Demonstrate various methods for turning a person on his/her side;
  - iii) Demonstrate various methods for moving a person to the head of the bed;
  - iv) Demonstrate various methods for moving a person to the side of the bed;
  - v) Demonstrate various types of lifts; and
  - vi) Recognize the CNA's role in lifting and moving;
- J) Discuss repositioning skills:
  - i) Identify the purpose of repositioning;
  - ii) Explain the principles of repositioning;
  - iii) Demonstrate various types of positions; and
  - iv) Recognize the CNA's role in repositioning the resident;
- K) Discuss transfer skills:
  - i) Explain the principles of transferring a person safely;
  - ii) Demonstrate various procedures for transferring a resident using a transfer/gait belt, including the proper application of a transfer/gait belt;
  - iii) Demonstrate various procedures for transferring a resident to a stretcher; and

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- iv) Recognize the CNA's role in transferring a resident;
    - L) Discuss ambulating skills:
      - i) Discuss the importance of ambulation;
      - ii) Explain the principles of ambulation;
      - iii) Describe assistive devices used for ambulation, such as transfer/gait belts, walkers and canes; and
      - iv) Demonstrate various ambulation techniques and recognize the CNA's role in ambulation of a resident;
    - M) Discuss transporting skills:
      - i) Explain the principles of transporting;
      - ii) Demonstrate various methods of transporting a person; and
      - iii) Recognize the CNA's role in transporting the resident.
  - 8) Gastrointestinal System. Objectives: upon completion of this unit, the student will be able to:
    - A) Identify the structures of the gastrointestinal system;
    - B) Identify the functions of the gastrointestinal system;
    - C) Discuss how age-related changes in the gastrointestinal system may affect a person's life physically, psychologically and socially;
    - D) Discuss basic nutrition:
      - i) Identify the importance of nutrition;
      - ii) Discuss healthy nutrition based on the daily requirements; and

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- iii) Identify basic food groups and discuss factors affecting a person's nutrition;
- E) Discuss hydration:
  - i) Identify the importance of hydration;
  - ii) Explain the principles of hydration; and
  - iii) Discuss factors affecting a person's hydration;
- F) Discuss therapeutic diets/nourishments:
  - i) Identify the purpose of therapeutic diets/nourishments;
  - ii) Explain the principles of therapeutic diets/nourishments;
  - iii) Describe the various types of therapeutic diets;
  - iv) Identify the various types of supplements and nourishments; and
  - v) Recognize the CNA's role in caring for the person receiving a therapeutic diet/nourishment;
- G) Discuss dining experience:
  - i) Identify the importance of creating a positive dining experience;
  - ii) Explain the principles involved in the dining experience;
  - iii) Describe methods of creating a person-directed dining experience;
  - iv) Discuss types of dining experiences, including restaurant style and buffet; and

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- v) Recognize the CNA's role in supporting the dining experience;
- H) Discuss assistance with the dining experience:
  - i) Identify the importance of providing assistance during dining;
  - ii) Explain the principles involved in providing assistance during dining, which include positioning, prep and set up, and assistive devices;
  - iii) Demonstrate safety measures when assisting with the dining experience;
  - iv) Demonstrate assisting the person to eat according to established standards;
  - v) Demonstrate adaptations for assisting a person with special needs. Special needs may include, but are not limited to, visual and cognitive impairment;
  - vi) Discuss special concerns, such as recognizing indications of dysphagia, squirreling or pocketing of food, and aspiration;
  - vii) Demonstrate aspiration precautions; and
  - viii) Recognize the CNA's role in assisting with the dining experience;
- I) Discuss bowel elimination:
  - i) Identify the characteristics of normal bowel elimination;
  - ii) Identify the resident's normal bowel habits/patterns;
  - iii) Discuss the factors affecting bowel elimination;

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- iv) Discuss how age-related changes affect bowel elimination;
  - v) Describe common health concerns association with bowel elimination, which include, but are not limited to, constipation and diarrhea;
  - vi) Recognize the CNA's role regarding bowel elimination;
  - vii) Demonstrate assisting a resident with bowel elimination procedures, which include, but are not limited to, bedpans, commodes, briefs and incontinent care, according to established standards; and
  - viii) Describe the procedures for collecting a stool specimen.
- 9) Urinary System. Objectives: upon completion of this unit, the student will be able to:
- A) Identify the structures of the urinary system;
  - B) Identify the functions of the urinary system;
  - C) Discuss how age-related changes in the urinary system may affect a person's life physically, psychologically and socially;
  - D) Describe common health concerns associated with urinary elimination, including urinary tract infection and incontinence;
  - E) Discuss intake and output:
    - i) Explain the purpose of measuring intake and output;
    - ii) Describe the guidelines for intake and output;
    - iii) Demonstrate the measurement of intake and output, according to established standards; and
    - iv) Recognize the CNA's role in caring for the person on intake and output;

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- F)     Discuss urinary elimination:
- i)     Identify characteristics of normal urinary elimination;
  - ii)    Identify the person's urinary elimination habits/patterns;
  - iii)   Discuss factors affecting urinary elimination;
  - iv)    Demonstrate the procedure for assisting a person to use a urinal, bedpan or commode/toilet;
  - v)     Describe the use of various incontinence products;
  - vi)    Identify types of urinary incontinence;
  - vii)   Describe methods of prevention of urinary incontinence;
  - viii)  Describe the CNA's role in the care of the incontinent resident;
  - ix)    Discuss the purpose of urinary catheters;
  - x)     Describe the types of urinary catheters;
  - xi)    Describe the CNA's role in caring for a resident with an indwelling urinary catheter;
  - xii)   Describe the procedures for collecting various urinary specimens; and
  - xiii)  Recognize the CNA's role in regard to urinary elimination.
- 10)    The Reproductive System. Objectives: upon completion of this unit, the student will be able to:
- A)     Identify the structures of the reproductive system;
  - B)     Identify the functions of the reproductive system;

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- C) Discuss how age-related changes in the reproductive system may affect a person's life physically, psychologically and socially;
  - D) Differentiate between sex and sexuality, including:
    - i) Discuss promoting sexuality;
    - ii) Recognize the importance of maintaining sensitivity related to a person's sexuality; and
    - iii) Discuss ways that a person may inappropriately express sexuality and describe interventions that the CNA may use when caring for sexually aggressive residents and residents who display inappropriate sexually explicit public behaviors;
  - E) Discuss common health concerns of sexually transmitted diseases:
    - i) Define sexually transmitted diseases;
    - ii) Identify the various types of sexually transmitted diseases;
    - iii) Describe the signs and symptoms of the various sexually transmitted diseases; and
    - iv) Recognize the CNA's role in caring for a person with a sexually transmitted disease.
- 11) The Cardiovascular System. Objectives: upon completion of this unit, the student will be able to:
- A) Identify the structures of the cardiovascular system;
  - B) Identify the functions of the cardiovascular system;
  - C) Discuss how age-related changes in the cardiovascular system may affect a person's life physically, psychologically and socially;

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- D) Identify the signs/symptoms of various cardiovascular diseases, which include, but are not limited to:
    - i) Hypertension;
    - ii) Coronary artery disease;
    - iii) Angina pectoris;
    - iv) Myocardial infarction; and
    - v) Congestive heart failure;
  - E) Recognize the CNA's role in caring for a person with a cardiovascular disease;
  - F) Discuss dietary modification related to cardiovascular diseases; and
  - G) Describe the role of the CNA in the application and removal of anti-embolism stockings (TED hose).
- 12) The Respiratory System. Objectives: upon completion of this unit, the student will be able to:
- A) Identify the structures of the respiratory system;
  - B) Identify the functions of the respiratory system;
  - C) Discuss how age-related changes in the respiratory system may affect a person's life physically, psychologically and socially;
  - D) Discuss common health concerns:
    - i) Identify various types of chronic obstructive pulmonary diseases (COPD);
    - ii) Discuss the psychosocial needs of the resident with COPD;

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- iii) Describe the signs and symptoms of various respiratory illnesses, which include asthma, pneumonia and tuberculosis; and
    - iv) Recognize the CNA's role in caring for a person with a respiratory illness;
  - E) Discuss oxygen therapy:
    - i) Identify the purpose of oxygen therapy;
    - ii) Explain the principles involved in oxygen therapy;
    - iii) Identify the types of oxygen delivery;
    - iv) Recognize the CNA's role in caring for a person receiving oxygen therapy;
    - v) Identify the purpose of artificial ventilation; and
    - vi) Recognize the CNA's role in caring for a person with a ventilator;
  - F) Identify the purposes of sputum collection and explain the procedure used when collecting a sputum specimen;
  - G) Discuss vital signs:
    - i) Identify the purpose of measuring temperature;
    - ii) Identify the types of thermometers;
    - iii) Identify sites where temperature may be measured;
    - iv) Demonstrate obtaining an oral temperature according to established standards;
    - v) Identify the purpose of measuring the pulse;

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- vi) Identify the sites where a pulse may be measured;
  - vii) Demonstrate obtaining a pulse according to established standards;
  - viii) Identify the purpose of measuring respirations;
  - ix) Discuss various respiratory patterns;
  - x) Demonstrate obtaining respiration according to established standards;
  - xi) Identify the purpose of measuring blood pressure;
  - xii) Explain the principles involved in obtaining a blood pressure;
  - xiii) Demonstrate obtaining a blood pressure according to established standards; and
  - xiv) Recognize the CNA's role in measuring vital signs;
- H) Discuss CPR:
- i) Discuss the purpose of performing CPR;
  - ii) Explain the principles involved in providing CPR;
  - iii) Demonstrate the performance of CPR, including one-rescuer adult, child and infant CPR and two rescuer adult, child and infant CPR;
  - iv) Demonstrate the performance of foreign airway obstruction for adult, child and infant victims; and
  - v) Recognize the CNA's role related to CPR.
- 13) The Nervous System. Objectives: upon completion of this unit, the student will be able to:

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- A) Identify the structures of the nervous system;
- B) Identify the functions of the nervous system;
- C) Discuss how age-related changes in the nervous system may affect a person's life physically, psychologically and socially;
- D) Discuss common health concerns:
  - i) Discuss the signs and symptoms of various nervous disorders, including cerebrovascular accident, Parkinson's disease, multiple sclerosis and types of traumatic injuries;
  - ii) Identify communication problems resulting from hearing disorders;
  - iii) Discuss communication strategies when caring for a person with a hearing disorder;
  - iv) Identify special concerns associated with caring for a person with a visual disorder;
  - v) Discuss ways the CNA can promote independence of a person with a visual disorder; and
  - vi) Recognize the CNA's role in caring for a person with various nervous system disorders, including observations, critical thinking, documentation and reporting;
- E) Discuss hearing instrument skills:
  - i) Identify the purpose of hearing instruments;
  - ii) Discuss the various types of hearing instruments;
  - iii) Explain the insertion and removal of the hearing instrument; and



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rehabilitation/restorative care.

- 6) Objective: upon completion of this unit, the student will be able to recognize the CNA's role in providing rehabilitation/restorative care, which includes:
- A) Importance;
  - B) Care-giving modifications;
  - C) Observations;
  - D) Reporting; and
  - E) Documentation.
- 7) ADL Programs. Objectives: upon completion of this unit, the student will be able to:
- A) Describe the types of ADL programs available for persons needing rehabilitation/restorative care, which include, but are not limited to:
    - i) Eating;
    - ii) Dressing/grooming;
    - iii) Mobility; and
    - iv) Communication;
  - B) Explain the purpose of ADL programs;
  - C) Discuss adaptive devices:
    - i) Describe the adaptive devices available to assist with performance of ADL;
    - ii) Explain the purpose of adaptive devices; and

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iii) Recognize the CNA's role in caring for the person using an adaptive device, including importance, care-giving modification, observations, reporting and documentation.

h) Module VIII – End-of-Life Care

1) End-of-Life Issues. Objectives: upon completion of this unit, the student will be able to:

A) Discuss attitudes:

i) Discuss the impact that spiritual and cultural beliefs have on one's attitudes; and

ii) Examine one's feelings about providing care for the terminally ill person;

B) Explore legal issues associated with end-of-life care, which include, but are not limited to:

i) Self-determination;

ii) Guardianship;

iii) Advance directives, including the significance of living wills and power of attorney; and

iv) Implications of do-not-resuscitate (DNR) orders and the Physician's Order for Life Sustaining Treatment (POLST).

2) State and Federal Regulations. Objectives: upon completion of this unit, the student will be able to discuss current State and federal regulations related to end-of-life issues, such as:

A) Resident rights;

B) Resident behaviors and facility practices;

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- C) Quality of life; and
  - D) Quality of care.
- 3) Care of a Dying Person. Objectives: upon completion of this unit, the student will be able to:
- A) Discuss physical aspects:
    - i) Identify the signs of approaching death;
    - ii) Discuss how to preserve the dying person's rights;
    - iii) Discuss ways to promote comfort for the dying person; and
    - iv) Recognize the CNA's role in meeting the physical needs of the dying person;
  - B) Discuss psychosocial aspects:
    - i) Discuss the importance of celebrating a person's life;
    - ii) Describe strategies to celebrate a person's life;
    - iii) Describe the grieving process as it may pertain to the dying person, friends/loved ones, and the care givers;
    - iv) Discuss various facility practices to honor deceased residents; and
    - v) Recognize the CNA's role in meeting the psychosocial needs of the dying person, which include observations, critical thinking, documentation and reporting;
  - C) Discuss hospice care and palliative care:
    - i) Discuss the philosophy of hospice and palliative care;
    - ii) Discuss the goals of hospice and palliative care; and

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- iii) Describe ways that hospice and palliative care are incorporated into the plan of care.
- 4) Post-mortem Care. Objectives: upon completion of this unit, the student will be able to:
- A) Explain the principles involved in caring for the body after death; and
  - B) Perform post-mortem care according to established facility practices.
- i) Module IX – Alzheimer's and Other Dementias
- 1) Cognitive Impairment. Objectives: upon completion of this unit, the student will be able to:
- A) Differentiate between normal aging and dementias;
  - B) Describe how dementias are diagnosed;
  - C) List types of reversible dementia; and
  - D) List types of non-reversible dementia.
- 2) Alzheimer's Disease. Objectives: upon completion of this unit, the student will be able to:
- A) Describe the physical changes that occur as the person progresses through Alzheimer's Disease; and
  - B) List the signs and symptoms of Alzheimer's Disease.
- 3) Impacts of Cognitive Impairments. Objectives: upon completion of this unit, the student will be able to describe the impact of cognitive impairment on society, the family and the individual.
- 4) State and Federal Regulations. Objectives: upon completion of this unit,

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the student will be able to discuss current State and federal regulations related to the care of the person with dementia.

5) Ability Centered Care:

A) Overview. Objectives: upon completion of this unit, the student will be able to:

- i) Discuss the philosophy of person-directed, ability-centered care;
- ii) Describe the goals of ability-centered care;
- iii) Discuss the importance of a team approach in caring for a person with dementia; and
- iv) Discuss the role of the CNA in providing ability-centered care;

B) Therapeutic Environment. Objectives: upon completion of this unit, the student will be able to:

- i) Discuss elements of a therapeutic environment; and
- ii) Discuss creative strategies to promote a therapeutic environment;

C) Communication. Objectives: upon completion of this unit, the student will be able to:

- i) Describe how challenges in communication change as the person progresses through the stages of dementia;
- ii) Discuss creative strategies to enhance communication; and
- iii) Discuss appropriate techniques for physical touch with someone with dementia;

D) Relationships. Objectives; upon completion of this unit, the

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student will be able to:

- i) Examine the importance of relationships between care givers and the person who has dementia; and
  - ii) Describe ways that the CNA can enhance his/her relationship with the person with dementia;
- E) Activities. Objectives: upon completion of this unit, the student will be able to:
- i) Discuss examples of activities appropriate for persons in different stages of dementia;
  - ii) Discuss approaches the CNA can use to engage residents in activities;
  - iii) Compare and contrast traditional versus non-traditional activities; and
  - iv) Compare and contrast structured versus spontaneous activities;
- F) Activities of Daily Living (ADL). Objectives: upon completion of this unit, the student will be able to:
- i) Discuss the purpose of restorative goals, including improving performance, maintaining abilities and preventing complications;
  - ii) Explore physical challenges, psychosocial challenges, environmental challenges and approaches to support resident's independence related to each ADL, which include, but are not limited to, dressing, bathing, grooming, oral hygiene, toileting and eating/nutritional issues.
- 6) Understanding Behaviors as Unmet Needs. Objectives: upon completion of this unit, the student will be able to:

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- A) Explain the difference between symptoms and behaviors;
- B) Describe defense mechanism/coping behaviors used to compensate for cognitive impairment;
- C) Examine ways in which the CNA can diminish behavioral challenges;
- D) Explore creative strategies to manage common behavioral challenges:
  - i) Purposeful wandering;
  - ii) Agitation and aggression;
  - iii) Catastrophic reaction;
  - iv) Combateness;
  - v) Delusions/hallucinations/paranoia;
  - vi) Rummaging and hoarding;
  - vii) Sexual behavior;
  - viii) Sleep disturbances;
  - ix) Sundowning;
  - x) Wanting to go home;
  - xi) Indifference;
  - xii) Purposeful waking; and
  - xiii) Other behaviors.
- 7) Safety. Objectives: upon completion of this unit, the student will be able to:

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- A) Describe challenges in maintaining the safety of the resident while supporting the resident's need to remain active. These include physical, psychosocial and environmental challenges; and
  - B) Investigate creative strategies to provide for the safety of the person with dementia.
- 8) Psychosocial Needs. Objectives: upon completion of this unit, the student will be able to:
- A) Discuss the Person with Dementia:
    - i) Describe role changes and reversals that the person with dementia experiences;
    - ii) Identify stressors;
    - iii) Discuss grief and loss issues; and
    - iv) Describe coping strategies for the person with dementia, including understanding disease progression, realistic expectations and self-care;
  - B) Discuss Family and Loved Ones:
    - i) Describe the role changes and reversals that family members go through when a loved one has dementia;
    - ii) Describe ways to manage the stresses of caring for persons with cognitive impairment;
    - iii) Discuss grief and loss issues; and
    - iv) Discuss the psychological support that family and loved ones might need in coping with dementia;
  - C) Discuss Caregivers and Staff:

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- i) Identify stressors;
    - ii) Discuss grief and loss issues; and
    - iii) Describe coping strategies for those caring for persons with cognitive impairment, including understanding disease progression, realistic expectations, self-care and recognizing burnout.
  - 9) Resources. Objectives: upon completion of this unit, the student will be able to identify community resources available to the following:
    - A) Persons with dementia;
    - B) Families and loved ones; and
    - C) Caregivers and staff.
- a) ~~Module I—Introduction to Health Care Systems~~
  - 1) ~~Functions of health care facilities. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - A) ~~differentiate between the hospital, long term care facility, and home health aide programs as to their basic purposes and what each expects of the nursing assistant;~~
    - B) ~~define the functions of the nursing assistant and be aware of the ethical implications and the legal limitations; and~~
    - C) ~~develop a beginning understanding and appreciation of the responsibility of the nursing assistant as a member of the health care team.~~
  - 2) ~~Home Health Agencies and the health care professions. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - A) ~~discuss the purpose and organization of a home health agency;~~

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- ~~B) identify the members of the home health care team and their respective tasks; and~~
  - ~~C) apply learned basic nursing procedures to the home setting making appropriate modifications.~~
- 3) ~~Philosophy of patient care. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- ~~A) understand the uniqueness and reward of caring for the geriatric patient;~~
  - ~~B) demonstrate an awareness of the ethics involved in the position; and~~
  - ~~C) develop an understanding of the patient family relationship.~~
- 4) ~~The role of the multidisciplinary health care team. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- ~~A) define the role of the nursing assistant in the long term care facility;~~
  - ~~B) identify and discuss roles of the multidisciplinary team and the integration of services for the total care of the patient; and~~
  - ~~C) identify the "chain of command" in the organizational structure of a long term care facility.~~
- 5) ~~Personal qualities of the nursing assistant. Objectives: Upon completion of this unit of instruction, the student will meet expectations of facilities by being able to:~~
- ~~A) meet standards of appearance and general behavior;~~
  - ~~B) be aware of the importance of punctuality and confidentiality; and~~



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- ~~individual needs; and~~
- C) ~~maintain reasonable care of the personal possessions of residents.~~
- 2) ~~Communication and interpersonal relationships with patients, families and others. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~develop an awareness of appropriate communication between staff/patients, staff/families, families/patient, staff/staff;~~
- B) ~~develop communication techniques; and~~
- C) ~~demonstrate the ability to understand verbal and nonverbal communication.~~
- 3) ~~Psychological needs of patient and family. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~develop an awareness of sensitivity to the patient's need for feelings of self-worth;~~
- B) ~~demonstrate the ability to listen; and~~
- C) ~~understand the necessity to develop and maintain harmony between patient and and family.~~
- 4) ~~Normal growth and development. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~list and describe various priorities of need of residents;~~
- B) ~~describe the continuum of life cycle; and~~
- C) ~~develop an awareness of normalcy and deviations.~~
- e) ~~Module III—Your working environment.~~
- 1) ~~Cleanliness in the health care setting and patient homes.~~

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~~Objectives: Upon completion of this unit of instruction, the student will be able to:~~

- ~~A) define the principles of medical asepsis;~~
- ~~B) demonstrate an awareness of the importance of cleanliness in health care institutions; and~~
- ~~C) demonstrate the ability to modify medical asepsis technique for the home setting.~~

~~2) Principles of handwashing. Objectives: Upon completion of this unit of instruction, the student will be able to:~~

- ~~A) discuss the need for handwashing before and after each task and before and after direct patient contact;~~
- ~~B) demonstrate that an understanding of a good handwashing technique will prevent the spread of disease; and~~
- ~~C) demonstrate the ability to wash hands using the learned technique.~~

~~3) Principles of disinfection. Objectives: Upon completion of this unit of instruction, the student will be able to:~~

- ~~A) List the methods of disinfection;~~
- ~~B) demonstrate an awareness of handling disinfected articles; and~~
- ~~C) differentiate between "clean" and "dirty."~~

~~4) Principles of sterilization. Objectives: Upon completion of this unit of instruction, the student will be able to:~~

- ~~A) explain the relationship between microorganisms and infection control;~~
- ~~B) list the conditions necessary for microorganism growth; and~~



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- A) ~~identify potential fire hazards;~~
  - B) ~~identify and apply facility's procedures for safety, fire and disaster; and~~
  - C) ~~state his/her role in facility's fire and disaster plan.~~
- 3) ~~Disaster. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~identify designated supervisory personnel in the event of disaster;~~
  - B) ~~develop an understanding of the disaster manual; and~~
  - C) ~~state his/her role in facility's safety, fire and disaster plan.~~
- 4) ~~Heimlich maneuver. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~list signs of choking; and~~
  - B) ~~demonstrate the Heimlich maneuver.~~
- e) ~~Module V—The patient's unit. Bedmaking procedures (unoccupied and occupied). Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- 1) ~~identify the patient's need for a clean and comfortable environment;~~
  - 2) ~~identify the purpose of the procedure for making the unoccupied and occupied bed; and~~
  - 3) ~~demonstrate proper bedmaking procedure.~~
- f) ~~Module VI—Lifting, moving and transporting patients.~~
- 1) ~~In bed. Objectives: Upon completion of this unit of instruction, the student will be able to:~~

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- A) ~~describe briefly the musculo-skeletal system;~~
  - B) ~~realize needs for motion in joints and muscle activity; and~~
  - C) ~~maintain correct body alignment.~~
- 2) ~~Ambulatory. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~safely ambulate patients;~~
  - B) ~~demonstrate proper body mechanics; and~~
  - C) ~~develop an awareness of the physical ability of each patient.~~
- 3) ~~Wheelchair. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~apply safety principles involved in transporting patient in wheelchair;~~
  - B) ~~demonstrate proper body mechanics; and~~
  - C) ~~provide for privacy when transferring the patient from bed to wheelchair.~~
- 4) ~~Stretcher. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~identify and apply rules for safety for patient transfer;~~
  - B) ~~demonstrate good body mechanics; and~~
  - C) ~~provide for privacy when transferring the patient from bed to stretcher.~~
- g) ~~Module VII—Basic Anatomy.~~
- 1) ~~Contents:~~

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- A) ~~Anatomy of the Skeletal System;~~
  - B) ~~Anatomy of the Circulatory System;~~
  - C) ~~Anatomy of the Digestive System;~~
  - D) ~~Anatomy of the Respiratory System;~~
  - E) ~~Anatomy of the Urinary System;~~
  - F) ~~Anatomy of the Muscular System; and~~
  - G) ~~Functioning of the human body as related to the disease process.~~
- 2) ~~Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~develop an understanding of human anatomy and its relationship to normal function;~~
  - B) ~~identify and discuss simple disease processes; and~~
  - C) ~~explain how body systems work together.~~
- h) ~~Module VIII—Personal care of the patient.~~
- 1) ~~Contents:~~
    - A) ~~Oral hygiene;~~
    - B) ~~Bathing procedures;~~
    - C) ~~Care of the back feet and skin; and~~
    - D) ~~Observing and reporting.~~
  - 2) ~~Objectives: Upon completion of this unit of instruction, the student will be able to:~~

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- A) ~~identify basic human needs (physical, emotional, social and religious) of the patient;~~
  - B) ~~demonstrate the ability to recognize basic human needs in patient behavior;~~
  - C) ~~demonstrate proper medical asepsis technique;~~
  - D) ~~demonstrate methods to detect incipient or manifest decubitus ulcers;~~
  - E) ~~demonstrate measures to prevent decubitus ulcers, such as proper positioning and turning;~~
  - F) ~~identify the patient's need for a clean environment; and~~
  - G) ~~observe and report care given.~~
- i) ~~Module IX—Nutrition.~~
- 1) ~~Diets and therapeutic diets.—Objectives:—Upon completion of this unit of instruction, the student will be able to:~~
    - A) ~~describe briefly the use of basic nutrients and fluids by the body;~~
    - B) ~~list the basic four groups and name daily requirements of each; and~~
    - C) ~~identify modified diets and understand the reasons for modification.~~
  - 2) ~~Feeding techniques.—Objectives:—Upon completion of this unit of instruction, the student will be able to:~~
    - A) ~~describe briefly the anatomy of digestion;~~
    - B) ~~develop an awareness of the patient's eating limitations; and~~
    - C) ~~serve and assist patient with feeding.~~

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- 3) ~~Nourishments. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
  - A) ~~develop an understanding of intermittent nourishments and dietary supplements;~~
  - B) ~~demonstrate the ability to properly distribute nourishments; and~~
  - C) ~~accurately report and record diet and fluid intake.~~
- j) ~~Module X—Fluid balance.~~
  - 1) ~~Measuring fluid intake and output. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - A) ~~describe briefly the anatomy of elimination;~~
    - B) ~~demonstrate the ability to measure intake and output; and~~
    - C) ~~accurately report and record intake and output.~~
  - 2) ~~Forcing and restricting fluids. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - A) ~~identify problems associated with bowel and bladder management;~~
    - B) ~~develop an understanding of fluid balance in the body; and~~
    - C) ~~accurately report and record patient's fluid intake.~~
  - 3) ~~Specimen collection. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - A) ~~describe briefly the anatomy related to body discharge and elimination;~~
    - B) ~~demonstrate how to collect stool, urine, and other specimens; and~~

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- ~~C) accurately report and record urinary, fecal, and other output.~~
- k) ~~Module XI—Observing and recording vital signs.~~
  - 1) ~~Contents:~~
    - A) ~~Taking the temperature;~~
    - B) ~~Taking pulse;~~
    - C) ~~Taking respirations;~~
    - D) ~~Taking blood pressure;~~
    - E) ~~Recording vital signs; and~~
    - F) ~~Measuring height and weight.~~
  - 2) ~~Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - A) ~~state the meaning and importance of temperature, pulse, respirations, and blood pressure;~~
    - B) ~~demonstrate how to properly measure temperature, pulse, respirations, and blood pressure;~~
    - C) ~~accurately report and record temperature, pulse, respirations, and blood pressure; and~~
    - D) ~~Demonstrate how to accurately measure and record height and weight.~~
- l) ~~Module XII—Supportive care.~~
  - 1) ~~Heat applications. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - A) ~~describe the various methods of heat application;~~

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- ~~B) demonstrate the use of safety measures involved in applying hot applications; and~~
  - ~~C) report and record treatment given.~~
- 2) ~~Cold applications. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
  - ~~A) describe the various methods of cold application;~~
  - ~~B) demonstrate the use and safety measures involved in applying cold applications; and~~
  - ~~C) report and record treatment given.~~
- 3) ~~Enemas. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
  - ~~A) describe briefly the anatomy of elimination;~~
  - ~~B) demonstrate how to administer an enema; and~~
  - ~~C) accurately report and record the procedures and results.~~
- 4) ~~The vaginal douche—external and internal. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
  - ~~A) describe briefly the anatomy of the reproductive system;~~
  - ~~B) demonstrate the procedure of administering an external and internal douche; and~~
  - ~~C) accurately report and record the procedure.~~
- 5) ~~Catheters and tubing. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
  - ~~A) develop a basic understanding of the use of catheters and tubing;~~

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- ~~B) discuss the use of specific catheters and tubing; and~~
  - ~~C) develop an understanding of the maintenance and storage of catheters and tubing.~~
- m) ~~Module XIII—Fundamentals of Rehabilitation Nursing.~~
- 1) ~~Philosophy of rehabilitation nursing. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - ~~A) discuss the intrinsic worth of affected persons;~~
    - ~~B) develop a beginning understanding of the fundamentals of rehabilitation; and~~
    - ~~C) identify methods of treating the whole patient for restoration of function.~~
  - 2) ~~Principles of rehabilitation nursing. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - ~~A) demonstrate an understanding of the concepts of rehabilitation nursing;~~
    - ~~B) identify the four cardinal principles of rehabilitation nursing; and~~
    - ~~C) develop an awareness of the treatment process of rehabilitation as well as the legal implications.~~
  - 3) ~~Concepts of activities of daily living. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - ~~A) describe and discuss the use of adaptive tools for the disabled person;~~
    - ~~B) develop an awareness of sensitivity to the patient's need for feelings of self-esteem; and~~

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- ~~C) motivate the patient to work toward independence and self care.~~
- n) ~~Module XIV—Patient care planning.~~
  - 1) ~~Contents:~~
    - ~~A) Patient admission;~~
    - ~~B) Patient transfer; and~~
    - ~~C) Patient discharge.~~
  - 2) ~~Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - ~~A) be aware of the emotional implications of admission, transfer, and discharge;~~
    - ~~B) demonstrate the procedures for admission, transfer, and discharge; and~~
    - ~~C) observe, report, and record accurately.~~
- o) ~~Module XV—The patient in isolation.~~
  - 1) ~~Isolation techniques. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
    - ~~A) discuss communicable diseases and the nature of isolation techniques;~~
    - ~~B) differentiate between "clean" and "dirty"; and~~
    - ~~C) discuss the difference between regular and reverse isolation procedures.~~
  - 2) ~~Physiological aspects of isolation. Objectives: Upon completion of this unit of instruction, the student will be able to:~~

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- A) ~~demonstrate isolation precautions and procedures;~~
  - B) ~~demonstrate isolation procedures including handwashing, masking, gowning, food and elimination precautions; and~~
  - C) ~~accurately report and record isolation procedures.~~
- 3) ~~Psychological aspects of isolation. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~be aware and empathetic to the patient's fear and loneliness;~~
  - B) ~~identify untoward behavior of the isolated patient; and~~
  - C) ~~accurately observe and record patient's emotional reaction to the isolation process.~~
- 4) ~~Isolation in the home. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- A) ~~apply learned isolation techniques making necessary modifications for home care;~~
  - B) ~~communicate effectively with the patient and family relevant to the isolation process; and~~
  - C) ~~accurately observe, report, and record the isolation techniques.~~
- p) ~~Module XVI—Care of the terminally ill patient.~~
- 1) ~~Contents:~~
    - A) ~~Psychological needs of the patient; and~~
    - B) ~~Psychological needs of the family.~~
  - 2) ~~Objectives: Upon completion of this unit of instruction, the student will be able to:~~

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- A) ~~identify and describe the rights of the dying patient and his/her family;~~
  - B) ~~discuss attitudes and feelings about death and dying;~~
  - C) ~~describe the physical and psychological changes in the patient as death approaches; and~~
  - D) ~~discuss the grieving process of the patient and family.~~
- q) ~~Module XVII—Care of the body (postmortem care). Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- 1) ~~develop an awareness for respect for the body after death occurs;~~
  - 2) ~~develop an understanding for good body alignment after death; and~~
  - 3) ~~demonstrate nursing care after death.~~
- r) ~~Module XVIII—Aging and Dementia. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- 1) ~~Identify the differences between the normal aging process and cognitive dysfunction disease processes;~~
  - 2) ~~Define dementia and pseudo-dementia:~~
    - A) ~~Reversible; and~~
    - B) ~~Non-reversible;~~
  - 3) ~~List the common terminology used to describe different types of dementia:~~
    - A) ~~Alzheimer's disease (AD);~~
    - B) ~~Senile Dementia of the Alzheimer's Type (SDAT);~~
    - C) ~~Multi-Infaret Dementia (MID); and~~

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- ~~D) Organic Brain Syndrome (OBS);~~
- ~~4) Discuss how dementias are currently diagnosed.~~
- s) ~~Module XIX—Alzheimer's Disease and Related Disorders (RD).  
Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- ~~1) Identify the potential health, social and economic impacts of AD and RD:~~
- ~~A) Society;~~
- ~~B) Family; and~~
- ~~C) Individual.~~
- ~~2) List the primary signs, symptoms and associated features of AD and RD.~~
- ~~3) Discuss memory loss, sensory impairments, perceptual dysfunction, and cognitive and physical changes normally associated with AD and RD.~~
- t) ~~Module XX—Communications. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- ~~1) Identify the elements of verbal/nonverbal communication between staff/resident;~~
- ~~2) Discuss the expected language and communication changes in AD and RD residents;~~
- ~~3) Identify effective techniques for enhancing communications; and~~
- ~~4) Discuss the importance of touch and companionship to the AD and RD resident.~~
- u) ~~Module XXI—Care and Treatment Modalities. Objective: Upon completion of this unit of instruction, the student will be able to:~~
- ~~1) Discuss the inter-disciplinary nature of treatment in the care of AD and~~

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~~RD residents;~~

- ~~2) Identify the importance of observation and ways to monitor the behavior and safety of the AD and RD resident;~~
  - ~~3) Identify the importance of: consistency in approach; focusing on ability; task breakdown techniques; clueing and distraction techniques;~~
  - ~~4) Discuss the difference in approaching activities of daily living (ADL), such as dressing, bathing, grooming, oral hygiene, bowel, bladder, and skin care;~~
  - ~~5) List the physical changes and their effects on the AD resident.~~
- v) ~~Module XXII—Behavior Issues and Management Techniques. Objectives:~~  
~~Upon completion of this unit of instruction, the student will be able to:~~
- ~~1) Discuss the common mood and behavioral disturbances of residents with a progressive dementing disorder:~~
    - ~~A) Agitation;~~
    - ~~B) Anxiety;~~
    - ~~C) Catastrophic Reactions;~~
    - ~~D) Clinging;~~
    - ~~E) Combativeness;~~
    - ~~F) Delusions/hallucinations;~~
    - ~~G) Inappropriate sexual behaviors;~~
    - ~~H) Rummaging/hoarding;~~
    - ~~I) Sleep disturbance;~~
    - ~~J) Sundowning (increasing intensity of symptoms during evening~~

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- hours);
- K) ~~Suspiciousness; and~~
  - L) ~~Wandering/pacing.~~
- 2) ~~Identify specific techniques or approaches used to support residents ability:~~
- A) ~~Behavior;~~
  - B) ~~Cause;~~
  - C) ~~Staff intervention/response; and~~
  - D) ~~Environment.~~
- w) ~~Module XXIII—Activities. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- 1) ~~Identify appropriate activities based on the individuals mood and behavioral needs:~~
    - A) ~~Individual;~~
    - B) ~~Small group; and~~
    - C) ~~Large group.~~
  - 2) ~~Discuss the importance, significance and types of familiar tasks to support normalization.~~
- x) ~~Module XXIV—Nutrition and Dietary Factors. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- 1) ~~Identify cognitive and physiological changes of AD and RD residents that affect nutrition and feeding patterns;~~
  - 2) ~~Discuss potential feeding problems, complications, and eating behaviors;~~

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and

- 3) ~~List approaches for maintaining good nutrition and enhancing mealtime.~~
- y) ~~Module XXV—Family Role and Community Resources. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- 1) ~~Define family, significant other, and the sandwich generation (individuals caring for both their children and their elderly parents);~~
  - 2) ~~Identify role changes and role reversal;~~
  - 3) ~~Discuss the extent of family caregiving prior to Nursing Home placement;~~
  - 4) ~~Discuss the impact of chronic stress on family systems;~~
  - 5) ~~Discuss the impact of caring for the AD and RD family member or resident on the primary caregiver;~~
  - 6) ~~Identify interventions appropriate for assisting family caregivers to cope with their stress;~~
  - 7) ~~Identify the different community resources available and their role in the care and treatment of AD and RD residents both inside and outside the facility setting; and~~
  - 8) ~~Discuss how local chapter of the Alzheimer's Disease and Related Disorders Association (ADRDA) can assist the resident, the family caregiver and the facility.~~
- z) ~~Module XXVI—Staff Support. Objectives: Upon completion of this unit of instruction, the student will be able to:~~
- 1) ~~Identify stress factors involved in caring for persons with irreversible cognitive decline;~~
  - 2) ~~Identify coping mechanisms used by the individual resident to compensate for irreversible cognitive decline; and~~

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- 3) ~~Identify coping mechanisms that are used during the death, dying and bereavement process by the family and facility staff.~~
- aa) ~~Module XXVII—Cardiopulmonary Resuscitation. Objective: Upon completion of this unit of instruction, the student will be able to initiate basic cardiopulmonary resuscitation. After the training, certification in the provision of basic life support by an American Heart Association or American Red Cross certified training program may be offered as an option for this unit, but such certification is not a pre-requisite for the student's satisfactory completion of this unit of instruction.~~

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

**Section 395.310 Developmental Disabilities Aide Training Program (Repealed)**

~~The Developmental (DD) Disabilities Aide Training Program shall include the following values, themes, and principles, which are considered to be current best practice by the developmental disabilities service system leaders in the field: active treatment, advocacy, choice/preference, communication/active listening, confidentiality, documentation, involvement/participation, normalization/age appropriate outcomes for people, people first language, quality assurance, respect/dignity, rights/responsibilities, self advocacy/empowerment, customer satisfaction, and appreciation for diversity. At a minimum, the curriculum will also include the following:~~

- a) ~~Orientation~~
  - 1) ~~Functions of long term care facilities for individuals with developmental disabilities~~
  - 2) ~~The health care professions, support services for individuals with developmental disabilities and community social service agencies~~
  - 3) ~~Philosophy of residential care and community living~~
  - 4) ~~Role of the interdisciplinary team~~
  - 5) ~~Job duties and responsibilities of the DD Aide~~
- b) ~~Introduction to the Residents~~

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- 1) ~~Types and styles of communication with residents~~
  - 2) ~~Communication and interpersonal relationships with residents, families and others~~
  - 3) ~~Psychosocial needs of residents, their family, and others~~
  - 4) ~~The growth and development process~~
  - 5) ~~Characteristics and types of developmental disabilities~~
  - 6) ~~Resident's adjustment to death and dying~~
- e) ~~Fundamentals of Habilitation Planning~~
- 1) ~~Philosophy of achieving independent living skills~~
  - 2) ~~Introduction of the individual habilitation plan including the role of each employee in the habilitation process~~
  - 3) ~~Habilitation plan assessment procedures and goal/future planning~~
  - 4) ~~The role of the employee in the admission, transfer and discharge processes~~
  - 5) ~~The role of the employee in basic resident care planning and procedures~~
- d) ~~Techniques of Habilitation Planning and Implementation. The role of the employee in social habilitation, including:~~
- 1) ~~Activities of daily living (ADL)~~
  - 2) ~~Therapeutic and leisure time activities~~
  - 3) ~~Education~~
  - 4) ~~Community living adjustment~~
  - 5) ~~Behavior development~~

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- 6) ~~Behavior management and self control~~
- 7) ~~Effect of drugs in behavior management and illness~~
- 8) ~~Effective total communication~~
- 9) ~~Pre-vocational and vocational training~~
- 10) ~~Nutrition and fluid intake~~
- 11) ~~Diets and therapeutic diets~~
- e) Principles of Record Keeping
  - 1) ~~History and use of facility records with special emphasis on the role of the employee in the record keeping process~~
  - 2) ~~Content and organization of resident records~~
  - 3) ~~Recording methods for progress notes, universal notes, ADC notes and habilitation reviews~~
  - 4) ~~Writing effective progress notes~~
  - 5) ~~Confidentiality~~
  - 6) ~~Recording admission, transfer and discharge information~~
- f) Safety
  - 1) ~~Basic fire safety~~
  - 2) ~~Emergency and disaster procedures~~
  - 3) ~~Injury prevention techniques~~
  - 4) ~~Household daily safety procedures including body mechanics~~

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- g) ~~Facility Environment~~
  - 1) ~~Creating normalized environment for daily living activities~~
  - 2) ~~Importance of cleanliness of the facility, use of equipment and supplies~~
- h) ~~Principles of Disease Control~~
  - 1) ~~Introduction to micro-organisms causing resident illness and disease~~
  - 2) ~~Teaching of disinfection and sanitation~~
- i) ~~Emergency Medical Procedures~~
  - 1) ~~Cardiopulmonary resuscitation (CPR)~~
  - 2) ~~Seizures~~
  - 3) ~~Drug reactions~~
  - 4) ~~Traumas~~
  - 5) ~~Heimlich maneuver~~
- j) ~~Resident Rights~~
  - 1) ~~Basic civil, human and legal rights of residents~~
  - 2) ~~Protection of residents' personal property~~
- k) ~~Bodily Functions~~
  - 1) ~~Helping residents to understand their body functions~~
  - 2) ~~Personal hygiene~~
  - 3) ~~Human sexual behavior~~

(Source: Repealed at 37 Ill. Reg. 10546, effective June 27, 2013)

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**Section 395.320 Direct Support Person~~Basic Child Care/Habilitation Aide~~ Training Program**

The Direct Support Person Training Program shall include the following values, themes and principles, which are considered to be current best practice by the developmental disabilities service system leaders in the field: abuse and neglect issues; active treatment; advocacy; choice/preference; communication/active listening; confidentiality; documentation; involvement/participation; age-appropriate outcomes; people-first language; quality assurance; respect/dignity; rights/responsibilities; self-advocacy/empowerment; client satisfaction; and appreciation for diversity. At a minimum, the curriculum shall also include the following:

- a) Orientation:
  - 1) Functions of developmental disabilities programs, or other living or service programs, licensed or certified by the Department or by the Department of Human Services for individuals with developmental disabilities who require DSPs;
  - 2) The health care professions and support services for individuals with developmental disabilities and community social service agencies;
  - 3) Philosophy of community inclusion;
  - 4) Role of the interdisciplinary team; and
  - 5) Job duties and responsibilities of the Direct Support Person.
- b) Introduction to the Clients:
  - 1) Types and styles of communicating with people;
  - 2) Communication and interpersonal relationships;
  - 3) Psychosocial needs;
  - 4) The growth and development process;
  - 5) Characteristics and types of developmental disabilities; and

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6) A client's adjustment to death and dying.

c) Fundamentals of Habilitation Planning:

1) Philosophy of achieving independent living skills:

2) Introduction to the individual habilitation plan, including the role of each employee in the habilitation process;

3) Habilitation plan assessment procedures and goal/future planning;

4) The role of the employee in the admission, transfer and discharge processes; and

5) The role of the employee in basic habilitation planning and procedures.

d) Techniques of Habilitation Planning and Implementation. The role of the employee in social habilitation, including:

1) ADLs;

2) Therapeutic and leisure time activities;

3) Education;

4) Community living adjustment;

5) Behavior development;

6) Behavior management and self-control;

7) Effect of drugs in behavior management and illness;

8) Effective total communication;

9) Pre-vocational and vocational training;

10) Nutrition and fluid intake; and

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- 11) Diets and therapeutic diets.
- e) Principles of Record Keeping:
  - 1) The history and use of facility records with special emphasis on the role of the employee in the record-keeping process;
  - 2) The content and organization of resident records;
  - 3) Recording methods for progress notes, universal notes, ADL notes and habilitation reviews;
  - 4) Writing effective progress notes;
  - 5) Confidentiality; and
  - 6) Recording admission, transfer and discharge information.
- f) Safety:
  - 1) Basic fire safety;
  - 2) Emergency and disaster procedures;
  - 3) Injury prevention techniques; and
  - 4) Household daily safety procedures, including body mechanics.
- g) Facility Environment:
  - 1) Creating a normalized environment for daily living activities; and
  - 2) The importance of cleanliness of the facility, use of equipment and supplies.
- h) Principles of Disease Control:
  - 1) Introduction to micro-organisms that cause resident illness and disease;

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and

2) The teaching of disinfection and sanitation.

i) Emergency Medical Procedures:

1) CPR;

2) Seizures;

3) Drug reactions;

4) Traumas; and

5) Airway obstruction clearing procedures.

j) Client Rights:

1) Basic civil, human and legal rights of clients; and

2) Protecting clients' personal property.

k) Bodily Functions:

1) Helping clients to understand their bodily functions;

2) Personal hygiene; and

3) Human sexual behavior.

~~The Basic Child Care/Habilitation Aide Training Program shall include at a minimum:~~

a) ~~Orientation:~~

1) ~~Functions of health care facilities.~~

2) ~~Health care professions.~~

3) ~~Philosophy of resident care.~~

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- 4) ~~The role of the interdisciplinary or multidisciplinary health care team.~~
- 5) ~~Personal qualities of the Aide.~~
- 6) ~~Duties of the Aide.~~
- 7) ~~Medical terminology.~~
- 8) ~~Record keeping.~~
- 9) ~~Residents' rights.~~
- b) ~~Introduction to the resident.~~
  - 1) ~~Communication and interpersonal relationships with residents, families and others.~~
  - 2) ~~Psychological needs of resident and family.~~
  - 3) ~~Normal growth and development.~~
  - 4) ~~Characteristics of developmental disabilities and mental illnesses.~~
- e) ~~Your working environment.~~
  - 1) ~~Cleanliness in the health care setting.~~
  - 2) ~~Principles of handwashing.~~
  - 3) ~~Principles of disinfection.~~
  - 4) ~~Principles of sterilization.~~
  - 5) ~~Techniques of disinfection.~~
  - 6) ~~Maintaining equipment and supplies.~~
- d) ~~Safety.~~

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- 1) ~~Body mechanics.~~
- 2) ~~Fire safety.~~
- 3) ~~Disaster.~~
- e) ~~Emergency Medical Procedures.~~
  - 1) ~~CPR.~~
  - 2) ~~Seizures.~~
  - 3) ~~Drug reactions.~~
  - 4) ~~Heimlich maneuver.~~
  - 5) ~~Trauma.~~
- f) ~~The resident's unit. Bedmaking procedures (unoccupied and occupied).~~
- g) ~~Lifting, moving and transporting residents.~~
  - 1) ~~In bed.~~
  - 2) ~~Ambulatory.~~
  - 3) ~~Wheelchair.~~
  - 4) ~~Stretcher.~~
- h) ~~Basic Anatomy.~~
  - 1) ~~Skeletal System.~~
  - 2) ~~Circulatory System.~~
  - 3) ~~Digestive System.~~

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- 4) ~~Respiratory System.~~
- 5) ~~Urinary System.~~
- 6) ~~Functioning of the human body as related to the disease process.~~
- i) ~~Personal care of the resident.~~
  - 1) ~~Oral hygiene.~~
  - 2) ~~Bathing procedures.~~
  - 3) ~~Care of the back, feet and skin.~~
  - 4) ~~Observing and reporting.~~
  - 5) ~~Personal hygiene.~~
- j) ~~Nutrition.~~
  - 1) ~~Diets and therapeutic diets.~~
  - 2) ~~Feeding techniques.~~
  - 3) ~~Nourishments.~~
  - 4) ~~Fluid intake.~~
- k) ~~Fluid balance.~~
  - 1) ~~Measuring fluid intake and output.~~
  - 2) ~~Forcing and restricting fluids.~~
  - 3) ~~Specimen collection.~~
- l) ~~Observing and recording vital signs.~~
  - 1) ~~Taking the temperature.~~

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- 2) ~~Taking pulse.~~
- 3) ~~Taking respirations.~~
- 4) ~~Taking blood pressure.~~
- 5) ~~Recording vital signs.~~
- m) ~~Supportive care.~~
  - 1) ~~Heat applications.~~
  - 2) ~~Cold applications.~~
  - 3) ~~Enemas.~~
  - 4) ~~The vaginal douche (external and internal).~~
  - 5) ~~Preparing the resident for surgery physiologically.~~
  - 6) ~~Preparing the resident for surgery psychologically.~~
  - 7) ~~Care for the post-operative resident's physiological needs.~~
  - 8) ~~Care for the post-operative resident's psychological needs.~~
  - 9) ~~Side effects of various medications.~~
- n) ~~Fundamentals of (Re)habilitation.~~
  - 1) ~~Physical.~~
  - 2) ~~Social.~~
  - 3) ~~Psychosocial.~~
  - 4) ~~Behavioral.~~

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- o) ~~Resident care planning.~~
  - 1) ~~Individual Habilitation Plan.~~
  - 2) ~~Individual Education Plan.~~
  - 3) ~~Admission.~~
  - 4) ~~Transfer.~~
  - 5) ~~Discharge.~~
  - 6) ~~Home visits.~~
- p) ~~The resident in isolation.~~
  - 1) ~~Isolation techniques.~~
  - 2) ~~Physiological aspects of isolation.~~
  - 3) ~~Psychological aspects of isolation.~~
- q) ~~Care of the terminally ill resident.~~
  - 1) ~~Psychological needs of the resident.~~
  - 2) ~~Psychological needs of the family.~~
- r) ~~Care of the body (Postmortem care).~~

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

SUBPART C: PROFICIENCY EXAMINATION

**Section 395.400 Proficiency Examination (BNATP Only)**

- a) The basic nursing assistant proficiency examination will be the Department-State- approved competency examination evaluation, with both written and performance manual skills components, developed from the curriculum outlined in

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## Section 395.300.

- 1) The written examination will be developed from a pool of standardized written test questions, only a portion of which are used in any one examination.
  - 2) The Department will verify that the written test questions address each course requirement as specified in the modules presented in Section 395.300.
  - 3) A facility may proctor the examination but shall not score it. Scoring will be done only by the Department or its designee.
  - 4) The skills demonstration part of the evaluation will require the student to exhibit the ability to perform each of the approved performance skills.
  - 5) A record of successful completion of the competency evaluation will be included in the Health Care Worker Registry.
- b) A student who has completed an approved BNATP shall be allowed three opportunities to pass the written competency examination within 12 months after the program completion date. Any examinee who fails to successfully pass the proficiency examination within the first 45 days of employment must enroll in and successfully complete an approved Basic Nursing Assistant Training Program or Developmental Disabilities Aide Training Program.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

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- 1) Heading of the Part: Emergency Medical Services and Trauma Center Code
- 2) Code Citation: 77 Ill. Adm. Code 515
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
515.720	Repealed
515.725	Amended
- 4) Statutory Authority: Emergency Medical Services (EMS) Systems Act [210 ILCS 50]
- 5) Effective Date of Rulemaking: June 25, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any material incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Notice of Proposed Amendments published in the *Illinois Register*: February 15, 2013; 37 Ill. Reg. 1850
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version:

No changes were made in response to comments received during the first notice or public comment period. No changes were made in response to comments and suggestions of JCAR.
- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were requested.
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any rulemakings pending on this Part? No

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- 15) Summary and Purpose of Rulemaking: The rules in Sections 515.720 and 515.725 have been combined as there is no longer a need for a First Responder-AED. Current National Standards now require all First Responders/Medical Emergency Responders to have AED training. Section 515.720 has been repealed and Section 515.725 has been amended to keep current with national standards for the First Responder/Emergency Medical Responder.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Susan Meister  
Division of Legal Services  
Department of Public Health  
535 West Jefferson, 5th Floor  
Springfield, Illinois 62761

217/782-2043  
e-mail: [dph.rules@illinois.gov](mailto:dph.rules@illinois.gov)

The full text of the Adopted Amendments begins on the next page:

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TITLE 77: PUBLIC HEALTH  
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH  
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETYPART 515  
EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE

## SUBPART A: GENERAL

Section	
515.100	Definitions
515.125	Incorporated and Referenced Materials
515.150	Waiver Provisions
515.160	Facility, System and Equipment Violations, Hearings and Fines
515.170	Employer Responsibility
515.180	Administrative Hearings

## SUBPART B: EMS REGIONS

Section	
515.200	Emergency Medical Services Regions
515.210	EMS Regional Plan Development
515.220	EMS Regional Plan Content
515.230	Resolution of Disputes Concerning the EMS Regional Plan
515.240	Bioterrorism Grants

## SUBPART C: EMS SYSTEMS

Section	
515.300	Approval of New EMS Systems
515.310	Approval and Renewal of EMS Systems
515.315	Bypass Status Review
515.320	Scope of EMS Service
515.330	EMS System Program Plan
515.340	EMS Medical Director's Course
515.350	Data Collection and Submission
515.360	Approval of Additional Drugs and Equipment
515.370	Automated Defibrillation (Repealed)
515.380	Do Not Resuscitate (DNR) Policy
515.390	Minimum Standards for Continuing Operation

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515.400	General Communications
515.410	EMS System Communications
515.420	System Participation Suspensions
515.430	Suspension, Revocation and Denial of Licensure of EMTs
515.440	State Emergency Medical Services Disciplinary Review Board
515.445	Pediatric Care
515.450	Complaints
515.455	Intra- and Inter-system Dispute Resolution
515.460	Fees
515.470	Participation by Veterans Health Administration Facilities

## SUBPART D: EMERGENCY MEDICAL TECHNICIANS

Section	
515.500	Emergency Medical Technician-Basic Training
515.510	Emergency Medical Technician-Intermediate Training
515.520	Emergency Medical Technician-Paramedic Training
515.530	EMT Testing
515.540	EMT Licensure
515.550	Scope of Practice – Licensed EMT
515.560	EMT-B Continuing Education
515.570	EMT-I Continuing Education
515.580	EMT-P Continuing Education
515.590	EMT License Renewals
515.600	EMT Inactive Status
515.610	EMT Reciprocity
515.620	Felony Convictions
515.630	Evaluation and Recognition of Military Experience and Education
515.640	Reinstatement

## SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER, FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE, EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND TRAUMA NURSE SPECIALIST

Section	
515.700	EMS Lead Instructor
515.710	Emergency Medical Dispatcher
515.715	Provisional Licensure for First Responders and Emergency Medical Responders
515.720	First Responder <u>(Repealed)</u>

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515.725	<del>First Responder</del> / <u>Emergency Medical Responder</u> <del>First Responder—AED</del>
515.730	Pre-Hospital Registered Nurse
515.740	Emergency Communications Registered Nurse
515.750	Trauma Nurse Specialist
515.760	Trauma Nurse Specialist Program Plan

## SUBPART F: VEHICLE SERVICE PROVIDERS

Section	
515.800	Vehicle Service Provider Licensure
515.810	EMS Vehicle System Participation
515.820	Denial, Nonrenewal, Suspension and Revocation of a Vehicle Service Provider License
515.825	Alternate Response Vehicle
515.830	Ambulance Licensing Requirements
515.835	Stretcher Van Provider Licensing Requirements
515.840	Stretcher Van Requirements
515.845	Operation of Stretcher Vans
515.850	Reserve Ambulances
515.860	Critical Care Transport

SUBPART G: LICENSURE OF SPECIALIZED EMERGENCY  
MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

Section	
515.900	Licensure of SEMSV Programs – General
515.910	Denial, Nonrenewal, Suspension or Revocation of SEMSV Licensure
515.920	SEMSV Program Licensure Requirements for All Vehicles
515.930	Helicopter and Fixed-Wing Aircraft Requirements
515.935	EMS Pilot Specifications
515.940	Aeromedical Crew Member Training Requirements
515.945	Aircraft Vehicle Specifications and Operation
515.950	Aircraft Medical Equipment and Drugs
515.955	Vehicle Maintenance for Helicopter and Fixed-wing Aircraft Programs
515.960	Aircraft Communications and Dispatch Center
515.965	Watercraft Requirements
515.970	Watercraft Vehicle Specifications and Operation
515.975	Watercraft Medical Equipment and Drugs
515.980	Watercraft Communications and Dispatch Center

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- 515.985 Off-Road SEMSV Requirements
- 515.990 Off-Road Vehicle Specifications and Operation
- 515.995 Off-Road Medical Equipment and Drugs
- 515.1000 Off-Road Communications and Dispatch Center

## SUBPART H: TRAUMA CENTERS

## Section

- 515.2000 Trauma Center Designation
- 515.2010 Denial of Application for Designation or Request for Renewal
- 515.2020 Inspection and Revocation of Designation
- 515.2030 Level I Trauma Center Designation Criteria
- 515.2035 Level I Pediatric Trauma Center
- 515.2040 Level II Trauma Center Designation Criteria
- 515.2045 Level II Pediatric Trauma Center
- 515.2050 Trauma Center Uniform Reporting Requirements
- 515.2060 Trauma Patient Evaluation and Transfer
- 515.2070 Trauma Center Designation Delegation to Local Health Departments
- 515.2080 Trauma Center Confidentiality and Immunity
- 515.2090 Trauma Center Fund
- 515.2100 Pediatric Care (Renumbered)
- 515.2200 Suspension Policy for Trauma Nurse Specialist Certification

## SUBPART I: EMS ASSISTANCE FUND

## Section

- 515.3000 EMS Assistance Fund Administration

## SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN

## Section

- 515.3090 Pediatric Recognition of Hospital Emergency Departments and Inpatient Critical Care Services
- 515.4000 Facility Recognition Criteria for the Emergency Department Approved for Pediatrics (EDAP)
- 515.4010 Facility Recognition Criteria for the Standby Emergency Department Approved for Pediatrics (SEDP)
- 515.4020 Facility Recognition Criteria for the Pediatric Critical Care Center (PCCC)

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515.APPENDIX A	A Request for Designation (RFD) Trauma Center
515.APPENDIX B	A Request for Renewal of Trauma Center Designation
515.APPENDIX C	Minimum Trauma Field Triage Criteria
515.APPENDIX D	Standing Medical Orders
515.APPENDIX E	Minimum Prescribed Data Elements
515.APPENDIX F	Template for In-House Triage for Trauma Centers
515.APPENDIX G	Credentials of General/Trauma Surgeons Level I and Level II
515.APPENDIX H	Credentials of Emergency Department Physicians Level I and Level II
515.APPENDIX I	Credentials of General/Trauma Surgeons Level I and Level II Pediatric Trauma Centers
515.APPENDIX J	Credentials of Emergency Department Physicians Level I and Level II Pediatric Trauma Centers
515.APPENDIX K	Application for Facility Recognition for Emergency Department with Pediatrics Capabilities
515.APPENDIX L	Pediatric Equipment Recommendations for Emergency Departments
515.APPENDIX M	Inter-facility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline
515.APPENDIX N	Pediatric Critical Care Center (PCCC)/Emergency Department Approved for Pediatrics (EDAP) Recognition Application
515.APPENDIX O	Pediatric Critical Care Center Plan
515.APPENDIX P	Pediatric Critical Care Center (PCCC) Pediatric Equipment/Supplies/Medications Requirements

AUTHORITY: Implementing and authorized by the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

SOURCE: Emergency Rule adopted at 19 Ill. Reg. 13084, effective September 1, 1995 for a maximum of 150 days; emergency expired January 28, 1996; adopted at 20 Ill. Reg. 3203, effective February 9, 1996; emergency amendment at 21 Ill. Reg. 2437, effective January 31, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 5170, effective April 15, 1997; amended at 22 Ill. Reg. 11835, effective June 25, 1998; amended at 22 Ill. Reg. 16543, effective September 8, 1998; amended at 24 Ill. Reg. 8585, effective June 10, 2000; amended at 24 Ill. Reg. 9006, effective June 15, 2000; amended at 24 Ill. Reg. 19218, effective December 15, 2000; amended at 25 Ill. Reg. 16386, effective December 20, 2001; amended at 26 Ill. Reg. 18367, effective December 20, 2002; amended at 27 Ill. Reg. 1277, effective January 10, 2003; amended at 27 Ill. Reg. 6352, effective April 15, 2003; amended at 27 Ill. Reg. 7302, effective April 25, 2003; amended at 27 Ill. Reg. 13507, effective July 25, 2003; emergency amendment at 29 Ill. Reg. 12640, effective July 29, 2005, for a maximum of 150 days; emergency expired December 25, 2005; amended at 30 Ill. Reg. 8658, effective April 21, 2006; amended at 32 Ill. Reg. 16255,

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effective September 18, 2008; amended at 35 Ill. Reg. 6195, effective March 22, 2011; amended at 35 Ill. Reg. 15278, effective August 30, 2011; amended at 35 Ill. Reg. 16697, effective September 29, 2011; amended at 35 Ill. Reg. 18331, effective October 21, 2011; amended at 35 Ill. Reg. 20609, effective December 9, 2011; amended at 36 Ill. Reg. 880, effective January 6, 2012; amended at 36 Ill. Reg. 2296, effective January 25, 2012; amended at 36 Ill. Reg. 3208, effective February 15, 2012; amended at 36 Ill. Reg. 11196, effective July 3, 2012; amended at 36 Ill. Reg. 17490, effective December 3, 2012; amended at 37 Ill. Reg. 5714, effective April 15, 2013; amended at 37 Ill. Reg. 7128, effective May 13, 2013; amended at 37 Ill. Reg. 10683, effective June 25, 2013.

SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER,  
FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE,  
EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND  
TRAUMA NURSE SPECIALIST

**Section 515.720 First Responder (Repealed)**

- a) ~~An individual who acts as a First Responder as part of an EMS System's Program Plan must be registered with the Department by August 1, 2000.~~
- b) ~~To register as a First Responder, the individual must submit the following to the Department:~~
  - 1) ~~A completed First Responder registration form prescribed by the Department, which shall include, but not be limited to, the First Responder's name, address, EMS System in which he or she participates as a First Responder, and the employer and supervisor when the individual is acting as a First Responder. (Section 3-60(b)(3) of the Act)~~
  - 2) ~~Documentation of successful completion of training in accordance with the National Standard Curriculum for First Responders or its equivalent and training in cardiopulmonary resuscitation.~~
  - 3) ~~Verification that the equipment listed in subsection (d) of this Section will be immediately available to the individual when he or she is acting as a First Responder.~~
- e) ~~Persons who have already completed a course of instruction in emergency first response based on or equivalent to the national curriculum of the United States~~

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~~Department of Transportation, or who were previously recognized by the Department as a First Responder on July 19, 1995, shall be considered First Responders (Section 3.60(a) of the Act) by submitting to the Department by July 1, 1997, a First Responder registration form and verification that the equipment listed in subsection (d) of this Section will be immediately available to the individual when he or she is acting as a First Responder.~~

- d) ~~As a minimum, when acting as a First Responder an individual shall have the following equipment immediately available:~~
- ~~1) triangular bandage;~~
  - ~~2) roller type bandage;~~
  - ~~3) universal dressing;~~
  - ~~4) gauze pad;~~
  - ~~5) occlusive dressing;~~
  - ~~6) bandage scissors;~~
  - ~~7) adhesive tape;~~
  - ~~8) stick (for impaled object/tourniquet);~~
  - ~~9) blanket;~~
  - ~~10) upper extremity splint;~~
  - ~~11) lower extremity splint (set);~~
  - ~~12) oxygen equipment and masks (adult and pediatric);~~
  - ~~13) a resuscitation device as specified by the EMS System;~~
  - ~~14) oropharyngeal airway (adult, child and infant);~~
  - ~~15) Face protection through any combination of masks, eye protection, and~~

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~~face shields; and~~

- ~~16) Any additional materials as required by the EMS System.~~
- e) ~~A First Responder shall notify the Department, in writing, within 10 days after any changes in:~~
- ~~1) EMS System participation;~~
  - ~~2) the First Responder's employer or supervisor; and~~
  - ~~3) name or address.~~

(Source: Repealed at 37 Ill. Reg. 10683, effective June 25, 2013)

**Section 515.725 First Responder/Emergency Medical Responder~~First Responder—AED~~**

- a) A First Responder/Emergency Medical Responder training program shall be pre-approved by the Department and conducted only by an EMS System or a community college under the direction of the EMS System.
- b) Applications for approval of First Responder/Emergency Medical Responder training programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum, name of applicant, agency and address, type of training program, dates of training program, and names and signatures of the EMS Medical Director (EMS MD) and EMS System Coordinator.
- c) Applications for approval, including a copy of the class schedule and course syllabus, shall be submitted at least 60 days in advance of the first scheduled class.
- d) The EMS MD of the EMS system shall attest on the application form that the training program shall be conducted according to the National EMS Educational Curriculum. The First Responder or Emergency Medical Responder training program shall include all components of the National EMS Educational Curriculum. The course hours shall minimally include 40 hours of didactic education.

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- e) The First Responder/Emergency Medical Responder training program shall designate an EMS Lead Instructor who shall be responsible for the overall management of the training program and shall be approved by the Department based on requirements of Section 515.700.
- f) The EMS MD shall electronically submit to the Department approval for licensure for a First Responder/Emergency Medical Responder candidate who is at least 18 years of age and has completed and passed all components of the training program, has passed the Final Examination, and has paid the appropriate initial licensure fee. The initial licensure fee may be waived pursuant to Section 515.460(c).
- g) All approved programs shall maintain class and student records for seven years, which shall be made available to the Department upon request.
- h) Continuing education classes, seminars, workshops, or other types of programs shall be approved by the Department before being offered to First Responder/Emergency Medical Responder candidates. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department at least 60 days prior to the scheduled event.
- i) Approval will be granted provided that the application is complete and the content of the program is based on topics or materials from the National EMS Educational Curriculum for the Emergency Medical Responder.
- j) A First Responder/Emergency Medical Responder shall be responsible for submitting written proof of continuing education attendance to the EMS System Coordinator or, for independent renewals, to the Department Regional EMS Coordinator. The EMS System Coordinator or Department Regional EMS Coordinator shall verify whether specific continuing education hours submitted by the First Responder/Emergency Medical Responder qualify for renewal.
- k) A First Responder/Emergency Medical Responder shall maintain copies of all documentation concerning continuing education programs that he or she has completed.
- l) A First Responder/Emergency Medical Responder license shall be valid for a period of four years. To be re-licensed as a First Responder/Emergency Medical Responder, the First Responder/Emergency Medical Responder shall submit an

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application for renewal with the Department, on a form prescribed by the Department, and the \$20 licensure renewal fee at least 30 days prior to the license expiration date. The renewal licensure fee may be waived pursuant to Section 515.460(c).

- 1) The submission of an electronic transaction by the EMS MD will satisfy the renewal application requirement for a First Responder/Emergency Medical Responder who has been recommended for re-licensure by the EMS MD.
  - 2) A First Responder/Emergency Medical Responder who has not been recommended for re-licensure by the EMS MD shall independently submit to the Department an application for renewal. The EMS MD shall provide the First Responder/Emergency Medical Responder with a copy of the application form.
- m) A written recommendation signed by the EMS MD shall be provided to the Department regarding completion of the following requirements:
- 1) 24 hours of continuing education every four years. The System shall define in the EMS Program Plan the number of continuing education hours to be accrued each year for re-licensure; and
  - 2) Current certification in CPR for Healthcare Providers in accordance with the standards of a nationally recognized organization such as the American Heart Association or American Red Cross, which includes both a didactic and clinical skills station.
- n) A First Responder/Emergency Medical Responder whose licensure has expired may, within 60 days after licensure expiration, submit all re-licensure material as required in this Part and a fee of \$50 in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in compliance with this Section and there is no disciplinary action pending against the First Responder/Emergency Medical Responder, the Department will re-license the First Responder/Emergency Medical Responder.
- o) First Responders who are not affiliated with an EMS system shall have equipment immediately available to provide the standard of care established by the National EMS Educational Curriculum for the First Responder.

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- a) ~~A person currently approved as a First Responder may utilize an automated external defibrillator (AED) if the First Responder:~~
- 1) ~~Has successfully completed a Department approved course in automated external defibrillator operation; and~~
  - 2) ~~Is functioning within a Department approved EMS System providing first response services as verified by the EMSMD. (Section 3.55(a-5) of the Act)~~
- b) ~~Continuing education classes, seminars, clinical time, workshops or other types of programs shall be approved by the Department before being offered to First Responder—AEDs. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department, at least 60 days prior to the scheduled event.~~
- e) ~~Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the United States Department of Transportation National Standard Curriculum for EMT Basic, Lesson 4-3, Cardiovascular Emergencies. Upon approval, the Department will issue a site code to the class, seminar, workshop or program.~~
- d) ~~A First Responder—AED shall be responsible for submitting written proof of continuing education attendance to the EMS System Coordinator or the Department Regional EMS Coordinator. The EMS System Coordinator or Department Regional EMS Coordinator shall be solely responsible for verifying whether specific continuing education hours have been earned by the First Responder—AED.~~
- e) ~~A First Responder—AED shall be responsible for maintaining copies of all documentation concerning continuing education programs that he or she has completed.~~
- f) ~~A First Respondent—AED registration shall be valid for a period of four years. To be re-registered as a First Responder—AED, the First Responder—AED shall file an application for renewal with the Department, on a form prescribed by the Department, at least 30 days prior to the license expiration date.~~

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- 1) ~~The submission of a transaction card (Form No. IL 482-0837) by the EMS Medical Director will satisfy the renewal application requirement for a First Responder—AED who has been recommended for re-registration by the EMS Medical Director.~~
- 2) ~~A First Responder—AED who has not been recommended for re-registration by the EMS Medical Director must independently submit to the Department an application for renewal. The EMS Medical Director shall provide the First Responder—AED with a copy of the appropriate form to be completed.~~
- g) ~~A written recommendation signed by the EMSMD must be provided to the Department regarding completion of the following requirements:~~
  - 1) ~~Twenty-four hours of continuing education every four years. The System shall define in the EMS Program Plan the number of continuing education hours to be accrued each year for re-registration; and~~
  - 2) ~~A current CPR for Healthcare Providers card that covers:~~
    - A) ~~Adult one-rescuer CPR,~~
    - B) ~~Adult foreign body airway obstruction management,~~
    - C) ~~Pediatric one-rescuer CPR,~~
    - D) ~~Pediatric foreign body airway obstruction management,~~
    - E) ~~Adult two-rescuer CPR, and~~
    - F) ~~AED.~~
- h) ~~At any time prior to the expiration of the current registration, a First Responder—AED may revert to First Responder status for the remainder of the registration period. The First Responder must make this request in writing to the Department. To re-register at the First Responder—AED level, the individual must meet the First Responder—AED requirements for re-registration.~~

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- i) ~~A First Responder—AED who has reverted to First Responder status may be subsequently re-registered as a First Responder—AED, upon the recommendation of an EMS Medical Director who has verified that the individual's knowledge and clinical skills are at an active First Responder—AED level, and that the individual has completed any retraining, education or testing deemed necessary by the EMSMD for resuming First Responder—AED activities.~~
- j) ~~Any First Responder—AED whose registration has expired for a period of more than 60 days shall be required to reapply for registration, complete the training program and pass the test.~~
- k) ~~A First Responder—AED whose registration has expired may, within 60 days after registration expiration, submit all re-registration material as required in this Part and a fee of \$50 in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in order and there is no disciplinary action pending against the First Responder—AED, the Department will re-register the First Responder—AED.~~

(Source: Amended at 37 Ill. Reg. 10683, effective June 25, 2013)

## STATE UNIVERSITIES RETIREMENT SYSTEM

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- 1) Heading of the Part: Universities Retirement
- 2) Code Citation: 80 Ill. Adm. Code 1600
- 3) Section Numbers: 1600.500                      Proposed Action: Amendment
- 4) Statutory Authority: 40 ILCS 5/15-177
- 5) Effective Date of Rulemaking: June 26, 2013
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any material incorporated, is on file in the Agency's principal office and is available for public inspection.
- 9) Notices of Proposed published in the *Illinois Register*: January 25, 2013; 37 Ill. Reg. 763
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: Various grammatical and technical changes have been made since this rulemaking was published on first notice.
- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any proposed rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
1600.700	Amendment	37 Ill. Reg. 6170; May 10, 2013
1600.710	Amendment	37 Ill. Reg. 6170; May 10, 2013
1600.715	Amendment	37 Ill. Reg. 6170; May 10, 2013
1600.720	Amendment	37 Ill. Reg. 6170; May 10, 2013
1600.745	Amendment	37 Ill. Reg. 6170; May 10, 2013

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1600.750                      Amendment                      37 Ill. Reg. 6170; May 10, 2013

15) Summary and Purpose of Rulemaking: Section 1600.500 is intended to update the Rules of Practice – Nature and Requirements of Formal Hearings.

16) Information and questions regarding this adopted rulemaking shall be directed to:

Michael B. Weinstein, General Counsel  
State Universities Retirement System  
1901 Fox Drive  
Champaign, IL 61820

217/378-8825 or 217/378-8838

The full text of the Adopted Amendment begins on the next page.

## STATE UNIVERSITIES RETIREMENT SYSTEM

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TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES  
SUBTITLE D: RETIREMENT SYSTEMS  
CHAPTER II: STATE UNIVERSITIES RETIREMENT SYSTEMPART 1600  
UNIVERSITIES RETIREMENT

## SUBPART A: GENERAL

## Section

- 1600.100 Definitions
- 1600.110 Freedom of Information Act
- 1600.120 Open Meetings Act
- 1600.130 Procurement

## SUBPART B: CONTRIBUTIONS AND SERVICE CREDIT

## Section

- 1600.202 Return to Employment
- 1600.203 Independent Contractors
- 1600.205 Compensation Subject to Withholding
- 1600.210 Crediting Interest on Participant Contributions and Other Reserves
- 1600.220 Election to Make Contributions Covering Leave of Absence at Less Than 50% Pay
- 1600.230 Election to Pay Contributions Based upon Employment that Preceded Certification as a Participant
- 1600.240 Election to Make Contributions Covering Periods of Military Leave Protected under USERRA
- 1600.241 Survivor Benefits for Members Who Die While on Military Leave Protected under USERRA
- 1600.250 Sick Leave Accrual Schedule
- 1600.260 Part-time/Concurrent Service Adjustment
- 1600.270 Employer Contributions for Benefit Increases Resulting from Earnings Increases Exceeding 6%

## SUBPART C: CLAIMS PROCEDURE AND EVIDENTIARY REQUIREMENTS

## Section

- 1600.300 Effective Beneficiary Designations
- 1600.305 Full-Time Student Survivors Insurance Beneficiaries

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- 1600.310 Dependency of Beneficiaries
- 1600.320 Disability Claims Procedure

## SUBPART D: BENEFIT CALCULATION AND PAYMENT

## Section

- 1600.400 Determination of Final Rate of Earnings Period
- 1600.410 Twenty Percent Limitation on Final Rate of Earnings Increases
- 1600.420 Making Preliminary Estimated Payments
- 1600.430 Excess Benefit Arrangement
- 1600.431 Indirect Payments to Minors and Legally Disabled Persons
- 1600.432 Indirect Payments to Child Survivors Through the Surviving Spouse
- 1600.440 Voluntary Deductions from Annuity Payments
- 1600.450 Overpayment Recovery

## SUBPART E: ADMINISTRATIVE REVIEW

## Section

- 1600.500 Rules of Practice – Nature and Requirements of Formal Hearings

## SUBPART F: QUALIFIED ILLINOIS DOMESTIC RELATIONS ORDERS

## Section

- 1600.600 Definitions
- 1600.605 Requirements for a Valid Qualified Illinois Domestic Relations Order
- 1600.610 Invalid Orders
- 1600.615 Filing a QILDRO with the System
- 1600.620 Modified QILDROs
- 1600.625 Benefits Affected by a QILDRO
- 1600.630 Effect of a Valid QILDRO
- 1600.635 QILDROs Against Persons Who Became Members Prior to July 1, 1999
- 1600.640 Alternate Payee's Address
- 1600.645 Electing Form of Payment
- 1600.650 Automatic Annual Increases
- 1600.655 Expiration of a QILDRO
- 1600.660 Reciprocal Systems QILDRO Policy Statement
- 1600.665 Providing Benefit Information for Divorce Purposes

## SUBPART G: BOARD TRUSTEE ELECTION

## STATE UNIVERSITIES RETIREMENT SYSTEM

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## Section

1600.700	Nomination of Candidates
1600.705	Election Date/Election Day – Defined
1600.710	Petitions
1600.715	Eligible Voters
1600.720	Election Materials
1600.725	Marking of Ballots
1600.730	Return of Ballots and Ballot Counting Process
1600.735	Certification of Ballot Counting
1600.740	Challenges to Election Results
1600.745	Candidate Informational Communication
1600.750	Filling a Vacancy in the Term of an Elected Trustee

AUTHORITY: Implementing and authorized by Section 15-177 of the Illinois Pension Code [40 ILCS 5/15-177].

SOURCE: Amended September 2, 1977; amended at 2 Ill. Reg. 31, p.53, effective July 30, 1978; amended at 7 Ill. Reg. 8139, effective June 29, 1983; codified at 8 Ill. Reg. 19683; amended at 11 Ill. Reg. 15656, effective September 9, 1987; amended at 13 Ill. Reg. 18939, effective November 21, 1989; amended at 14 Ill. Reg. 6789, effective April 20, 1990; emergency amendment at 21 Ill. Reg. 4864, effective March 26, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 6095, effective May 2, 1997; amended at 21 Ill. Reg. 11962, effective August 13, 1997; amended at 21 Ill. Reg. 12653, effective August 28, 1997; amended at 22 Ill. Reg. 4116, effective February 9, 1998; amended at 23 Ill. Reg. 13667, effective November 1, 1999; amended at 25 Ill. Reg. 10206, effective July 30, 2001; amended at 28 Ill. Reg. 2292, effective January 23, 2004; expedited correction at 28 Ill. Reg. 7575, effective January 23, 2004; amended at 29 Ill. Reg. 2729, effective March 1, 2005; amended at 29 Ill. Reg. 11819, effective July 12, 2005; amended at 29 Ill. Reg. 14060, effective September 1, 2005; amended at 29 Ill. Reg. 14351, effective September 6, 2005; amended at 30 Ill. Reg. 6170, effective March 21, 2006; amended at 30 Ill. Reg. 7778, effective April 5, 2006; amended at 30 Ill. Reg. 9911, effective May 9, 2006; amended at 30 Ill. Reg. 17509, effective October 19, 2006; amended at 31 Ill. Reg. 4267, effective February 22, 2007; amended at 31 Ill. Reg. 4927, effective March 12, 2007; recodified at 31 Ill. Reg. 10194; amended at 32 Ill. Reg. 16515, effective September 25, 2008; emergency amendment at 33 Ill. Reg. 6525, effective April 27, 2009, for a maximum of 150 days; emergency expired September 23, 2009; amended at 33 Ill. Reg. 10757, effective July 1, 2009; amended at 33 Ill. Reg. 16755, effective November 23, 2009; amended at 34 Ill. Reg. 9523, effective June 25, 2010; amended at 35 Ill. Reg. 10952, effective June 22, 2011; amended at 36 Ill. Reg. 3938, effective February 22, 2012; amended at 37 Ill. Reg. 1309, effective January

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15, 2013; amended at 37 Ill. Reg. 3866, effective March 15, 2013; amended at 37 Ill. Reg. 10698, effective June 26, 2013.

## SUBPART E: ADMINISTRATIVE REVIEW

**Section 1600.500 Rules of Practice – Nature and Requirements of Formal Hearings**

- a) **Administrative Determination**  
The SURS administrative staff shall be responsible for the daily claims-processing function of SURS, including processing of all claims for benefits or service credit or any other claims against or relating to SURS.
- b) **Review by Director of Member Services**  
Any participant, annuitant or beneficiary adversely affected by the disposition of a claim by the administrative staff may file a written request for review by the SURS Director of Member Services or such other person as may be designated by the Executive Director. The designee shall have all the powers and duties of the Director of Member Services, as set forth in this subsection (b). A request for review by the Director of Member Services must be ~~received~~submitted within ~~35~~30 days ~~from the date of~~after the decision from which review is sought. The Director of Member Services' review will be based upon all materials contained in the file, as well as any additional materials the claimant attaches to the written request for review filed with the Director of Member Services pertaining to the claim. All filings or submissions, whether optional or required under this Section, shall be considered timely if date stamped by SURS within the time prescribed. The Director of Member Services' decision shall be served on the participant, annuitant or beneficiary by delivery to a third-party commercial carrier or by registered or certified mail, return receipt requested.
- c) Review by the Claims Panel~~Hearing~~
- 1) A Claims Panel shall hear all administrative contested matters. The Panel shall meet periodically as determined by the Executive Director.
  - 2) Request for Review~~Petition~~. Any participant, annuitant or beneficiary (hereinafter "claimant") adversely affected by the disposition of a claim by the Director of Member Services may request, in writing, a review by hearing before the Claims Panel, as well as a copy of all relevant documents from the claimant's file. A request for ~~review~~a hearing must be

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~~received by~~~~submitted to~~ the General Counsel of SURS, or his or her designee, within ~~35~~~~30~~ days ~~from the date of~~~~after~~ the decision from which review is sought.

- ~~32)~~ Notice of Hearing Statement of Claim. Upon receipt of a claimant's Request for Review, the Director of Member Services, or his or her designee, shall assign the claim a docket number; schedule the claim for the first available meeting of the Claims Panel; and notify the claimant. ~~Upon filing a request for a hearing, the claimant shall be informed, by a Notice of Hearing,~~ that he or she is required to file a single Statement of Claim, no later than 30 days in advance of hearing. The Notice of Hearing may be accompanied by any relevant documentation from the claimant's file.
- ~~4)~~ Statement of Claim. The Statement of Claim must be received by the SURS General Counsel, or his or her designee, no later than 35 days from the date of the mailing of the Notice of Hearing. The Statement of Claim shall include: a formal Appearance, containing the claimant's name, SURS identification numbersocial security number and address; the name and address of the claimant's authorized representative, if any; a statement of the facts forming the basis for the appeal; any documents or other materials the claimant wishes to be considered in conjunction with the appeal, in addition to those already contained in the claimant's file; whether the claimant desires a hearing or whether the claimant desires to waive a hearing and allow the Claims Panel to reach a decision based upon the Statement of Claim and the relevant documents in the claimant's file; a list of witnesses, if any, the claimant intends to present at a hearing; and an explanation of the relief sought. The Statement of Claim shall not exceed 15 pages in length, unless an exception is granted by the Claims Panel Hearing Officer. The Hearing Officer may grant a motion to Strike/Dismiss all or part of the Statement of Claim.
- ~~53)~~ Notification. The Notice of Hearing shall also provide~~Upon scheduling of a hearing before the Claims Panel,~~ a claimant ~~shall be provided~~ with written notice of: the date, time and place of the hearing; the subject matter of the hearing; and relevant procedural and substantive statutory and regulatory provisions [5 ILCS 100/10-25]. The Notice of the hearing shall also inform the claimant that he or she will be afforded the opportunity to provide a statement of his or her position, present oral

## STATE UNIVERSITIES RETIREMENT SYSTEM

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evidence, and conduct examination and cross-examination of witnesses as necessary for full and true disclosure of the facts. Notice shall also be given to the claimant that he or she is required to provide written confirmation, at least ~~14~~three days prior to the scheduled date of the hearing, of his or her intent to appear at the hearing, whether in person or by telephone conference call. The claimant is not required to physically appear at the hearing. The claimant may appear at the hearing by telephone conference call. The claimant may also choose to affirmatively waive his or her appearance at the hearing. In the absence of the claimant, the Claims Panel will consider the claimant's Statement of Claim and such other matters as may be properly brought before it at the hearing.

~~64~~) Pre-hearing Conference. Upon request of the General Counsel or upon the decision of the Hearing Officer, a pre-hearing conference shall be held for the purpose of simplification or definition of issues or procedures at the hearing.

~~75~~) Representation. The claimant and SURS may be represented by counsel or a designated spokesperson at the hearing.

~~86~~) Burden of Proof. It shall be the burden of the claimant to establish a right to the benefit claimed, or the right to the continuation of the benefit claimed in cases of revocation of the benefit by SURS, by establishing that right by a preponderance of the evidence.

d) Discovery. All discovery is at the discretion of the Hearing Officer. Requests to take discovery must be made in writing to the Hearing Officer with notice to the other party. Discovery may be taken with the prior permission of the Hearing Officer only upon good cause shown, that is, if the evidence sought is material and cannot be obtained in any other way. Failure to comply with orders of the Hearing Officer may be sanctioned by the Hearing Officer, by means including, but not limited to, dismissal of a claim.

e) Depositions

1) The Hearing Officer may order the taking of evidence depositions of a person, specifying the subject matter to be covered, under oral examination or written questions, for use as evidence at the hearing, provided:

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- A) The Hearing Officer has determined upon request that there is a need to preserve a person's testimony. The need to preserve a person's testimony shall be determined using criteria similar to that set forth under Illinois Supreme Court Rule 212(b);
- B) The request is made on motion by a party who gives notice of the motion to the other party; and
- C) The Hearing Officer has determined that an evidence deposition containing oral testimony will be necessary to the Claims Panel in determining the merits of the claim.
- 2) The taking of depositions shall be in accordance with the provisions for taking depositions in civil cases, and the order for the taking of a deposition may provide that any designated books, papers, documents or tangible objects that are not privileged shall be produced at the same time and place.
- 3) Any party to the hearing shall, during any deposition process, have the right to confront and cross-examine any witness whose deposition testimony is to be presented to the Claims Panel.
- 4) Depositions shall be taken in the county of residence or employment of the witness, unless the witness waives that right in writing.
- 5) Depositions shall be taken at the cost of the party requesting the deposition.
- f) Subpoenas
- 1) The Hearing Officer may request the Secretary of the Board to issue a subpoena to compel the attendance of a witness at an evidence deposition or the production of documents when the witness has, or such documents contain, relevant evidence. A party may also request the Hearing Officer to request the Secretary of the Board to issue a subpoena to compel the attendance of a witness at an evidence deposition or the production of documents. The request shall either be in writing or on the record and shall:

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- A) Identify the witness or document sought; and
  - B) State the facts that will be proven by each witness or document sought.
- 2) The Hearing Officer shall grant or deny the request, either in writing or on the record. If the request for subpoena is granted, the Hearing Officer shall, if necessary, reschedule the hearing to a specific date. The request for subpoena shall be denied if the Hearing Officer finds that the evidence sought is immaterial, irrelevant or cumulative. If the request for subpoena is denied, the specific reasons for denial of the request shall be made part of the record on appeal.
  - 3) If a witness fails to obey a subpoena, the party seeking enforcement of the subpoena shall prepare an application to the circuit court of the county in which the subpoenaed witness resides requesting enforcement of the subpoena, and shall present the application to the Hearing Officer, at the same time serving a copy of the application upon the other party. If satisfied that the subpoena was properly served and that the application is in proper form, the Hearing Officer shall sign a subpoena to be submitted with the application and the party seeking the subpoena may then file and prosecute the application in the circuit court, in the name of the Board. The petitioner in the application shall be styled as "Name of Petitioner ex rel. Board of Trustees of the State Universities Retirement System of Illinois" unless the petitioner is SURS, in which case the petition shall be brought in the name of the Board. In the event of an application being filed with the circuit court, the matter shall be continued pending the outcome of the application to enforce the subpoena.
  - 4) The fees of witnesses for attendance and travel shall be the same as fees of witnesses before the circuit courts of this State and shall be paid by the party seeking the subpoena.
- g) Conduct of the Hearing
- 1) Hearing Officer. The hearing shall be conducted by the Hearing Officer. Other members of the Claims Panel may, but are not required to, attend the hearing. Members may attend hearings either in-person or by video or

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teleconference.

- A) The Hearing Officer shall have full power to conduct the hearing and the presence of any other members of the Claims Panel is not required. The Hearing Officer shall be one of the members of the Claims Panel chosen by the Panel to be the Hearing Officer.
  - B) The Claims Panel shall consist of:
    - i) the Executive Director of SURS;
    - ii) an attorney licensed to practice law in the State of Illinois approved by the Board; and
    - iii) one other person, selected by the Chairperson of the Board of Trustees of SURS, who shall be a member of the Board, a participant in SURS or an attorney licensed to practice law in the State of Illinois.
  - C) Each member of the Panel shall be reimbursed for travel or other related expenses incurred in connection with his or her duties as a member of the Panel. If he or she is not a member of the Board or currently employed by one of the employers covered by SURS, the member shall receive reasonable compensation, as recommended by the Executive Director and approved by the Board, for time spent in reviewing claims and attending Panel hearings. At a minimum, the members of the Claims Panel shall have a general familiarity with the provisions of the Illinois Pension Code, this Part and the internal operating procedures/policies of SURS.
- 2) Procedures
- A) The Hearing Officer shall conduct a full and fair hearing, receive testimony of the claimant and admit exhibits into evidence, avoid delay, maintain order and make a sufficient record for a full and true disclosure of the facts and issues.
  - B) To accomplish these ends, the Hearing Officer shall make all procedural and evidentiary rulings necessary for the conduct of the

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hearing.

- C) All testimony shall be taken under oath before an officer authorized to administer oaths by the laws of this State or of the United States or of the place where the testimony is to be given.
  - D) As a general matter, *the rules of evidence as applied in civil cases in the circuit courts of the State of Illinois shall be followed; however, evidence ~~inadmissible~~ inadmissable under those rules may be admitted (except where precluded by statute) if it is of a type commonly relied upon by reasonably prudent persons in the conduct of their affairs. Any part of the evidence may be received in written form, provided that the interests of the parties will not be prejudiced. Notice may be taken of generally recognized technical facts within SURS' specialized knowledge and SURS' experience, technical competence and specialized knowledge may be used in evaluation of the evidence.* [5 ILCS 100/10-40]
  - E) The Hearing Officer, and any member of the Claims Panel attending the hearing, may ask questions necessary for better understanding of the facts or law.
  - F) The Hearing Officer shall have the authority to impose reasonable time limits for each party to present its case and shall, in general, have the power to manage and control the hearing process.
  - G) The hearing shall be open to the public unless the Hearing Officer, for good cause shown, determines otherwise.
- 3) Record of Proceedings. Two records of proceedings shall be kept that shall be in the form of:
- A) a non-verbatim "bystander's report"; and
  - B) either a stenographic transcription or a tape recording. The claimant may obtain a stenographic transcription or a copy of a tape recording of the hearing by making a timely request within 21 days after the close of the hearing and paying the actual cost entailed.

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- 4) Disqualification; Ex Parte Communications
- A) Disqualification
- i) *A Hearing Officer or other member of the Claims Panel may be disqualified on grounds of bias or conflict of interest. A motion to disqualify a Hearing Officer or other member of the Claims Panel for bias or conflict of interest shall*~~should~~ *be made to the Hearing Officer by any party to the hearing at least ~~14 days~~<sup>one week</sup> prior to the commencement of the hearing, with a copy of the motion to be simultaneously submitted to the General Counsel. The motion shall be heard, considered and ruled upon by the Hearing Officer at or prior to the commencement of the hearing. The movant shall have the burden of proof with respect to the motion to disqualify. Either an *adverse ruling* or the fact that a Hearing Officer or other member of the Claims Panel is an employee of SURS or has a contract with SURS, standing alone, shall not constitute bias or conflict of interest. [5 ILCS 100/10-30]*
- ii) The Executive Director may not be called as a witness unless it is demonstrated that the Executive Director has relevant noncumulative personal knowledge of facts bearing upon the claim. The Executive Director may not be disqualified as a member of the Claims Panel on the basis that the Executive Director is responsible for the overall administration of SURS.
- iii) In the event that a Hearing Officer or other member of the Claims Panel is disqualified or is otherwise unable to serve, the Board ~~Chairperson~~<sup>President</sup> may appoint another person to the Claims Panel and shall appoint another person if the Claims Panel is reduced to fewer than two members, or the Claims Panel shall appoint another Hearing Officer from among its members, as the case may be.
- B) Ex Parte Communications Prohibited. *Except in the disposition of*

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*matters that SURS is authorized by law to entertain or dispose of on an ex parte basis, the members of the Claims Panel shall not, after receiving notice of a hearing in a contested matter, communicate, directly or indirectly, in connection with any issue of fact, with any party, or in connection with any other issue with any party, or the representative of any party, except upon notice and opportunity for all parties to participate. However, an employee of SURS may communicate with other employees of SURS and an employee of SURS or member of the Claims Panel may have the aid and advice of one or more assistants. An ex parte communication received by any member of the Claims Panel shall be made a part of the record of the pending matter, including all written communications, all written responses to the communications, and a memorandum stating the substance of all oral communications and all responses made and the identity of each person from whom the ex parte communication was received. Communications regarding matters of procedure and practice, such as the format of pleadings, number of copies required, manner of service, and status of proceedings, are not considered ex parte communications. [5 ILCS 100/10-60]*

## 5) Decisions of the Claims Panel and Executive Committee

## A) Claims Panel Decisions

- i) The record of proceedings shall be completed upon conclusion of the hearing by the Hearing Officer, unless the Hearing Officer determines to re-open the proceedings. Upon conclusion of all evidence and arguments, the Claims Panel shall privately deliberate and make a Decision as to the disposition of the claim based on the evidence of record. The Claims Panel Decision shall be served on all parties and their agents, if any, by delivery to a third-party commercial carrier or by registered or certified mail, return receipt requested. If a Statement of Exceptions to the Decision is not filed pursuant to this subsection (g)(5)(A), the Decision is final for all purposes and not subject to administrative or judicial review. However, iff a Statement of Exceptions to the Decision is filed or, if

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~~the two~~ members of the Panel are unable to agree on a Decision, then the claim shall be presented to the Executive Committee for a final administrative decision.

- ii) If a Statement of Exceptions is filed, it must be received by SURS, along shall be filed, with a brief in support, ~~with SURS~~ within ~~2120~~ days after the date of mailing of the Claims Panel Decision. Any responsive brief shall be ~~received~~ filed within ~~2115~~ days after the filing of the Statement of Exceptions. Any reply brief shall be ~~received~~ filed within ~~1410~~ days after the filing of the responsive brief. The filing of any responsive or reply brief is optional. The Executive Director, or his or her designee, shall provide the Executive Committee with a summary of the decision of the Claims Panel. The Executive Committee will make a final administrative decision based on the Claims Panel Decision, any dissenting opinion, any Statement of Exceptions and briefs properly filed.
- iii) If the claim is presented to the Executive Committee because ~~the two~~ members of the Claims Panel are unable to agree on a Decision, the Executive Committee shall make a final administrative decision based on any opinions of the Claims Panel members, the record and any briefs properly filed by the claimant or SURS. The filing of any opening, responsive or reply brief in response to the Claims Panel decision is optional. Any opening brief shall be received by filed with SURS within ~~2120~~ days after receiving notification from the Hearing Officer that the Claims Panel was unable to agree on a Decision. Any responsive brief shall be ~~received~~ filed within ~~2115~~ days after the filing of any opening brief. Any reply brief shall be ~~received~~ filed within ~~1410~~ days after the filing of any responsive brief.
- iv) All filings shall be served upon the opposing party and shall contain a certificate of service. Filing deadlines in this subsection (g)(5)(A) may be continued to a date certain by the Hearing Officer for good cause shown on written application filed with SURS prior to the expiration of the

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deadline sought to be continued.

- B) Executive Committee Decision
- i) When necessary pursuant to subsection (g)(5)(A), the Executive Committee of the Board shall make a decision on the claim. No oral argument shall be permitted before the Executive Committee unless otherwise determined by the Executive Committee.
  - ii) The Executive Committee shall render one of the following decisions with respect to the claim: affirmation of the administrative action, reversal of the administrative action, or remand of the case to the administrative staff for further consideration. Remand of the case to the administrative staff shall not be considered a final decision of the Executive Committee. A decision by the Executive Committee either reversing or affirming the decision of the administrative staff shall constitute a final decision for the purpose of review under the Administrative Review Law [735 ILCS 5/Art. III]. *A final decision of the Executive Committee shall be in writing or stated in the record. ~~A final decision of the Executive Committee shall include findings of fact and conclusions of law, separately stated.~~*
  - iii) The Executive Committee may adopt, as its own, the findings of fact and conclusions of law of the Claims Panel. *Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings.*
  - iv) *All decisions of the Executive Committee shall specify whether they are final and subject to the Administrative Review Law. [5 ILCS 100/10-50]*
  - v) Parties ~~and/or~~ and/or their agents, if any, shall be notified, ~~either~~ personally, ~~or~~ by delivery to a third-party commercial carrier, or by registered or certified mail, return receipt requested, of any decision of the Executive Committee.

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The date of mailing of the decision shall constitute the date of service for purposes of the Administrative Review Law or any other applicable law. ~~Upon request, a copy of the decision shall be delivered or mailed to each party and to his or her attorney of record.~~

(Source: Amended at 37 Ill. Reg. 10698, effective June 26, 2013)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF EMERGENCY AMENDMENTS

- 1) Heading of the Part: Financial Incentive for Non-Medicare Annuitants Who Opt Out of the State Employees Group Health Plan
- 2) Code Citation: 80 Ill. Adm. Code 2106
- 3) 

<u>Section Numbers:</u>	<u>Emergency Action:</u>
2106.110	Amendment
2106.120	Amendment
2106.130	Amendment
2106.140	Amendment
2106.210	Amendment
2106.220	Amendment
2106.310	Amendment
2106.320	Amendment
2106.330	Amendment
- 4) Statutory Authority: Implementing and authorized by Sections 8(d-5) and (d-6) of the State Employees Group Insurance Act [5 ILCS 375/8(d-5) and (d-6)]
- 5) Effective Date of Rulemaking: June 28, 2013
- 6) If this emergency rulemaking is to expire before the end of the 150-day period, please specify the date on which it is to expire: This rulemaking has no earlier effective date specified.
- 7) Date Filed with the Index Department: June 28, 2013
- 8) A copy of the emergency rulemaking, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Reason for Emergency: Public Act 98-19 was signed on June 10, 2013. In order to ensure that the program is in place for July 1, 2013, emergency rules are necessary.
- 10) A Complete Description of the Subjects and Issues Involved: These emergency rules expand the current opt out financial incentive program to apply to all eligible annuitants enrolled in the State Employees Group Insurance program regardless of the retirement system under which they retired. The rules also modify the amount of the incentive to give a greater benefit to those individuals with 20 or more years of service.

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- 11) Are there any rulemakings pending on this Part? An emergency amendment and companion identical proposed amendment are being filed simultaneously.
- 12) Statement of Statewide Policy Objectives: This rulemaking will not create a State mandate for units of local government.
- 13) Information and questions regarding this rulemaking shall be directed to:

Mary Matheny  
Department of Central Management Services  
720 Stratton Office Building  
Springfield, Illinois 62706

Phone: 217/557-5404  
Fax: 217/558-2697  
[mary.matheny@illinois.gov](mailto:mary.matheny@illinois.gov)

The full text of the Emergency Rulemaking begins on the next page.

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## NOTICE OF EMERGENCY AMENDMENTS

## TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES

## SUBTITLE F: EMPLOYEE BENEFITS

## CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## PART 2106

## FINANCIAL INCENTIVE FOR NON-MEDICARE

~~STATE EMPLOYEES RETIREMENT SYSTEM~~ ANNUITANTS WHO OPT OUT  
OF THE STATE EMPLOYEES GROUP HEALTH PLAN

## SUBPART A: GENERAL

## Section

2106.110 Governing Authority

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2106.120 Purpose

EMERGENCY

2106.130 Definitions of Terms

EMERGENCY

2106.140 Records and Certifications

EMERGENCY

2106.150 Severability

SUBPART B: RESPONSIBILITY FOR ADMINISTRATION  
OF THE OPT OUT INCENTIVE

## Section

2106.210 CMS Responsibility

EMERGENCY2106.220 ~~Annuitant~~Member ResponsibilityEMERGENCY

## SUBPART C: OPT OUT INCENTIVE REQUIREMENTS AND BENEFITS

## Section

2106.310 Eligibility Requirements

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2106.320 Participation Limits

EMERGENCY

2106.330 Enrollment

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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**EMERGENCY**

AUTHORITY: Implementing and authorized by Section 8(d-5) and (d-6) of the State Employees Group Insurance Act of 1971 [5 ILCS 375/8(d-5) and (d-6)].

SOURCE: Adopted by emergency rulemaking at 29 Ill. Reg. 15976, effective October 5, 2005, for a maximum of 150 days; modification of emergency rulemaking to meet the objection of the Joint Committee on Administrative Rules at 30 Ill. Reg. 138, effective December 22, 2005 and not to exceed the 150-day time limit of the original rulemaking; adopted at 30 Ill. Reg. 4597, effective March 1, 2006; emergency amendment at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days.

## SUBPART A: GENERAL

**Section 2106.110 Governing Authority****EMERGENCY**

The financial incentive for non-Medicare ~~State Employees Retirement System (SERS)~~ annuitants to opt out of the State Employees Group Insurance Health Plan will be governed by ~~PA~~Public Act 94-0109, PA 98-0019, the State Employees Group Insurance Act of 1971 [5 ILCS 375/8(~~d-5~~)], ~~as amended in 375/8 (see specifically Section 8(d-5) and (d-6))~~, and this Part.

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days)

**Section 2106.120 Purpose****EMERGENCY**

The purpose of this Part is to provide for administration of an Opt Out Incentive for non-Medicare ~~SERS~~ annuitants who elect not to participate in the Health Plan provided by Section 8(d-5) and (d-6) of the State Employees Group Insurance Act [~~5 ILCS 375/8(d-5)~~].

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days)

**Section 2106.130 Definitions of Terms****EMERGENCY**

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**Unless the context otherwise requires, the following words and phrases as used in the Act shall have the following meanings for the purpose of implementing and administering the Opt Out Incentive:**

"Act" means the State Employees Group Insurance Act [5 ILCS 375].

"Annuitant" means a retiree or annuitant who is receiving an annuity from one of the five State retirement systems.

"Benefit Choice Period" means a designated time when members may change benefit coverage elections.

"CMS" means the Illinois Department of Central Management Services.

"Director" means the Director of CMS.

"Health Plan" means the health, dental and vision benefits offered by the program to eligible persons.

~~"HFS" means the Illinois Department of Healthcare and Family Services.~~

"Major Medical Coverage" refers to policies that provide coverage for most health-related expenses that can be incurred. Coverage included in a major medical insurance policy usually includes prescription drugs; casts and other necessary equipment needed for bone breaks or fractures; x-rays; both outpatient and inpatient services as a result of required medical care; diagnostic tests and examinations; ambulance services; and necessary medical supplies and therapies. This coverage may include deductibles, coinsurance and co-payment requirements.

"Member" means an employee, annuitant, retired employee or survivor, as defined in the Act.

"Opt Out/In Qualifying Change in Status" means an event that effects eligibility for Health Plan coverage, including but not limited to the following:

~~member~~Member becomes eligible for non-State administered health benefits coverage; marriage; loss or gain of Medicare for any reason; coordination of spouse's open enrollment period; spouse gains or loses non-State administered health benefits.

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"Opt Out Incentive" means the ~~State Employees Retirement System~~ retiree/annuitant insurance opt out incentive authorized by Section 8(d-5) and (d-6) of the Act, which provides a financial incentive for each ~~State Employees Retirement System retiree/annuitant~~ who is not eligible for benefits under the federal Medicare health insurance program who elects not to participate in the Health Plan on or after January 1, 2006 under Section 8(d-5) of the Act and, on or after July 1, 2013, under Section 8(d-6) of the Act.

"Program" means the group life insurance, health and other benefits designed and/or contracted for by CMS ~~and/or HFS~~ that are provided under the Act.

"SERS" means the State ~~Employees'~~Employees Retirement System.

~~"SERS Annuitant" means a retiree or annuitant who is receiving a pension from the State Employees Retirement System.~~

"Special Enrollment Period" means a designated time period defined by the Director of CMS for certain ~~members~~Members to change specific benefit coverage elections when special circumstances occur that affect only those ~~members~~Members.

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days)

**Section 2106.140 Records and Certifications****EMERGENCY**

Records and other necessary certifications will be furnished to the Director as may be necessary for the administration of this ~~opt out incentive~~Opt-Out Incentive. These records and certifications will be retained and provided as necessary by the applicable retirement system~~SERS~~ and CMS.

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days.)

**SUBPART B: RESPONSIBILITY FOR ADMINISTRATION  
OF THE OPT OUT INCENTIVE**

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**Section 2106.210 CMS Responsibility****EMERGENCY**

CMS will be responsible for administering the opt out incentive~~Opt-Out Incentive~~ and shall:

- a) Develop and distribute materials and information to members~~Members~~ and the retirement systems, including any and all necessary forms with requirements, policies and procedures related to the opt out incentive~~Opt-Out Incentive~~.
- b) Maintain eligibility for the opt out incentive~~Opt-Out Incentive~~ in a centralized, computerized file, properly storing and retrieving confidential information, processing updates and administering security access in accordance with confidentiality laws.
- c) Authorize payments to annuitants~~Members~~ participating in the opt out incentive~~Opt-Out Incentive~~. No partial monthly or retroactive payments will be made.
- d) Assist members~~Members~~ with opt out incentive~~Opt-Out Incentive~~ questions and/or issues, and respond to oral and written inquiries concerning the opt out incentive~~Opt-Out Incentive~~.
- e) Comply with the federal Health Insurance Portability and Accountability Act (HIPAA), when~~where~~ applicable.
- f) Enroll and terminate annuitants~~Members~~ in compliance with this Part.
- g) Identify and collect opt out incentive~~Opt-Out Incentive~~ payments paid in error to annuitants~~Members~~ and deposit the money into the Health Insurance Reserve Fund.

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days)

**Section 2106.220 Annuitant~~Member~~ Responsibility****EMERGENCY**

The annuitant shall~~Member will be responsible to~~:

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- a) Furnish proof of ~~major medical coverage~~health coverage from a source other than CMS at the time of initial application and on an annual basis as required by CMS.
- b) Timely report~~Report~~ Medicare eligibility changes timely.
- c) Report all eligibility status changes within 60 days after the event, including but not limited to Medicare eligibility.
- d) Return to CMS all payments made in error or for fraudulent acts. Failure to repay payments as required will result in termination of the financial incentive and disallowance of future coverage in the Health Plan. Fraudulent acts include, but are not limited to, the following:
  - 1) failure to timely report changes and/or Opt Out/In Qualifying Changes in Status;
  - 2) falsifying information in order to receive opt out incentive~~Opt Out Incentive~~ payments.

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days)

## SUBPART C: OPT OUT INCENTIVE REQUIREMENTS AND BENEFITS

**Section 2106.310 Eligibility Requirements****EMERGENCY**

Opt out incentive~~Opt Out Incentive~~ administration shall be in compliance with Section 8(d-5) and (d-6) of the Act and shall:

- a) Allow ~~SERS~~-annuitants who elect not to participate in the Health Plan to receive a financial incentive not to exceed \$500~~of \$150~~ per month if all of the following conditions are met:
  - 1) the annuitant~~Member~~ is enrolled in the Health Plan on the effective date of PA 98-0019. at the time of a Special Enrollment Period or subsequent Benefit Choice Periods, or when an Opt Out/In Qualifying Change in Status occurs; ~~and~~

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- 2) the ~~annuitant~~~~Member~~ is not eligible for and/or receiving benefits under the federal Medicare health insurance program (42 USC §-1395 et seq.); ~~and-~~
- 3) the annuitant has 20 or more years of creditable service with the State of Illinois.
- b) Allow annuitants who elect not to participate in the Health Plan and meet the requirements of subsections (a)(1) and (a)(2) but fail to meet the requirements of subsection (a)(3) to receive a financial incentive not to exceed \$150 per month.
- c) Provide for a Special Enrollment Period from November 1 through November 30, 2005 for SERS annuitants enrolled in the Health Plan to elect to participate in the ~~opt out incentive~~~~Opt Out Incentive~~. The ~~opt out incentive~~~~Opt Out Incentive~~ elected by SERS annuitants during this Special Enrollment Period will have an effective date of January 1, 2006.
- d) Provide that ~~SERS~~ annuitants who previously elected not to participate in the Health Plan may choose to enroll in the Health Plan during the Benefit Choice Period or with an Opt Out/In Qualifying Change in Status. Once enrolled, they may take advantage of the ~~opt out incentive~~~~Opt Out Incentive~~ during a subsequent Benefit Choice Period or with a subsequent Opt Out/In Qualifying Change in Status. ~~Annuitants~~~~Participants~~ will not be permitted to enroll and opt out during the same Benefit Choice Period or based on the same Opt Out/In Qualifying Change in Status.

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days)

**Section 2106.320 Participation Limits****EMERGENCY**

Opt ~~out incentive~~~~Out Incentive~~ participation ~~shall cease~~~~ceases~~ when the non-Medicare ~~SERS~~ annuitant:

- a) reaches age 65, unless written proof of Medicare ineligibility is submitted to CMS;
- b) becomes Medicare eligible for any reason; or

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c) elects to participate in the Health Plan.

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days)

**Section 2106.330 Enrollment****EMERGENCY**

Eligible ~~annuitants~~Members participating in the Health Plan may enroll in the opt out incentive within 90 days after July 1, 2013~~Opt Out Incentive during the Special Enrollment Period~~, the annual Benefit Choice Period, or with an Opt Out/In Qualifying Change in Status by completing appropriate forms and furnishing proof of eligibility as outlined in Section 2106.310~~of this Part~~.

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 10715, effective June 28, 2013, for a maximum of 150 days)

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- 1) Heading of the Part: State Employees Group Insurance Program Retiree Premium Contributions
- 2) Code Citation: 80 Ill. Adm. Code 2200
- 3) 

<u>Section Numbers</u> :	<u>Emergency Action</u> :
2200.110	New Section
2200.120	New Section
2200.130	New Section
2200.140	New Section
2200.150	New Section
2200.210	New Section
2200.220	New Section
2200.230	New Section
2200.240	New Section
2200.250	New Section
2200.310	New Section
2200.320	New Section
2200.330	New Section
2200.410	New Section
2200.510	New Section
2200.520	New Section
2200.530	New Section
2200.540	New Section
2200.550	New Section
2200.560	New Section
- 4) Statutory Authority: Authorized by the State Employees Group Insurance Act of 1971 [5 ILCS 375]
- 5) Effective Date of Rulemaking: June 28, 2013
- 6) If this emergency rulemaking is to expire before the end of the 150-day period, please specify the date on which it is to expire: This rulemaking has no earlier effective date specified.
- 7) Date Filed with the Index Department: June 28, 2013

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- 8) A copy of the emergency rulemaking, including any material incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Reason for Emergency: This new Part will bring us into compliance with changes made to the State Employees Group Insurance Act, pursuant to PA 97-695, requiring these rules be filed as an emergency.
- 10) A Complete Description of the Subjects and Issues Involved: This new Part will bring CMS into compliance with changes made to the State Employees Group Insurance Act, pursuant to PA 97-695.
- 11) Are there any rulemakings pending on this Part? No
- 12) Statement of Statewide Policy Objectives: This rulemaking will not create a State mandate for units of local government.
- 13) Information and questions regarding this rulemaking shall be directed to:

Mary Matheny  
Department of Central Management Services  
720 Stratton Office Building  
Springfield, Illinois 62706

Phone: 217/557-5404  
Fax: 217/558-2697  
mary.matheny@illinois.gov

The full text of the Emergency Rulemaking begins on the next page.

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## TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES

## SUBTITLE F: EMPLOYEE BENEFITS

## CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## PART 2200

## STATE EMPLOYEES GROUP INSURANCE PROGRAM

## RETIREE PREMIUM CONTRIBUTIONS

## SUBPART A: PURPOSE AND DEFINITIONS

## Section

2200.110 Governing Authority

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2200.120 Purpose

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2200.130 Definitions

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2200.140 Records and Certifications

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2200.150 Severability

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## SUBPART B: RESPONSIBILITIES OF THE DEPARTMENT

## Section

2200.210 CMS Responsibility

EMERGENCY

2200.220 Determining Benefits

EMERGENCY

2200.230 Provision for Benefits

EMERGENCY

2200.240 Health Insurance Portability and Accountability Act (HIPAA)

EMERGENCY

2200.250 Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

EMERGENCY

## SUBPART C: RESPONSIBILITIES OF THE APPROPRIATE RETIREMENT SYSTEM

## Section

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY RULES

- 2200.310 Annuity  
EMERGENCY
- 2200.320 Enrollments and Terminations  
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- Section
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- 2200.540 Dependent Premiums  
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- 2200.550 Optional Coverage Premiums  
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- 2200.560 Exempt from Premiums  
EMERGENCY

AUTHORITY: Implementing and authorized by the State Employees Group Insurance Act of 1971 [5 ILCS 375].

SOURCE: Adopted by emergency rulemaking at 37 Ill. Reg. 10725, effective June 28, 2013, for a maximum of 150 days.

SUBPART A: GENERAL

- Section 2200.110 Governing Authority**  
**EMERGENCY**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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The State Employees Group Insurance Program Retiree Premium Contributions program is governed by the State Employees Group Insurance Act of 1971 [5 ILCS 375] and this Part.

**Section 2200.120 Purpose****EMERGENCY**

The purpose of this Part is to outline the premium amount that annuitants, survivors and retired employees of the General Assembly Retirement System, the State Employees' Retirement System, the State Universities Retirement System, the Teachers' Retirement System, and the Judges Retirement System will be required to contribute towards the cost of the basic program of group health benefits provided under the Act.

**Section 2200.130 Definitions****EMERGENCY**

Whenever used in this Part, the following terms shall have the meanings set forth in this Section unless otherwise expressly provided, and when the defined meaning is intended, the term is capitalized.

"Act" means the State Employees Group Insurance Act of 1971 [5 ILCS 375].

"Annuitant" means:

an employee who retires, or has retired, on or after January 1, 1966 on an immediate annuity under the provisions of Articles 2, 14 (including an employee who has elected to receive an alternative retirement cancellation payment under Section 14-108.5 of the Illinois Pension Code in lieu of an annuity), 15 (including an employee who has retired under the optional retirement program established under Section 15-158.2 of the Code), Section 16-106(2), (3) or (5) of the Code, or Article 18 of the Code;

any person who was receiving group insurance coverage under the Act as of March 31, 1978 by reason of his or her status as an annuitant, even though the annuity in relation to which the coverage was provided is a proportional annuity based on less than the minimum period of service required for a retirement annuity in the system involved;

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF EMERGENCY RULES

any person not otherwise covered by the Act who has retired as a participating member under Article 2 of the Code but is ineligible for the retirement annuity under Section 2-119 of the Code; or

the spouse of any person who is receiving a retirement annuity under Article 18 of the Code and who is covered under a group health insurance program sponsored by a governmental employer other than the State of Illinois and who has irrevocably elected to waive his or her coverage under the Act and to have his or her spouse considered as the "annuitant" under the Act and not as a "dependent".

"CMS" means the Illinois Department of Central Management Services.

"Code" means the Illinois Pension Code [40 ILCS 5].

"Department" means any Department, institution, board, commission, officer, court or any agency of the State government as defined in Section 3(g) of the Act.

"Director" means the Director of the Illinois Department of Central Management Services or of any successor agency designated to administer the Act.

"GARS" means the General Assembly Retirement System.

"JRS" means the Judges Retirement System.

"Retired Employee" means any person who would be an annuitant as that term is defined in this Section but for the fact that the person retired prior to January 1, 1966. The term also includes any person formerly employed by the University of Illinois in the Cooperative Extension Service who would be an annuitant but for the fact that the person was made ineligible to participate in SURS by Section 15-107(a)(4) of the Code.

"Retirement Systems" means the General Assembly Retirement System, the Judges Retirement System, the State Employees' Retirement System, the State Universities Retirement System and the Teachers' Retirement System.

"SERS" means the State Employees' Retirement System.

"SURS" means the State Universities Retirement System.

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"Survivor" means a person receiving an annuity as a survivor of an employee or of an annuitant. "Survivor" also includes:

the surviving dependent of a person who satisfies the definition of "employee" except that the person is made ineligible to participate in SURS by Section 15-107(a)(4) of the Code;

the surviving dependent of any person formerly employed by the University of Illinois in the Cooperative Extension Service who would be an annuitant except for the fact that the person was made ineligible to participate in SURS by Section 15-107(a)(4) of the Code; and

the surviving dependent of a person who was an annuitant under the Act by virtue of receiving an alternative retirement cancellation payment under Section 14-108.5 of the Code.

"TRS" means the Teachers' Retirement System.

**Section 2200.140 Records and Certifications**  
**EMERGENCY**

Records and other necessary certifications will be furnished to the Director as may be necessary for the administration of this Part. These records and certifications will be retained and provided as necessary by each appropriate Department.

**Section 2200.150 Severability**  
**EMERGENCY**

If any provision of the Act or this Part or application of the Act or this Part to any person or circumstance is held invalid, that invalidity does not affect other provisions or applications of the Act or this Part that can be given effect without the invalid application or provision. To this end, the provisions of the Act and this Part are declared to be severable.

SUBPART B: RESPONSIBILITIES OF THE DEPARTMENT

**Section 2200.210 CMS Responsibility**  
**EMERGENCY**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF EMERGENCY RULES

CMS shall:

- a) Establish premium contributions consistent with the Act and this Part;
- b) Calculate the premium contribution owed by each Retired Employee, Annuitant or Survivor and transmit that calculation to the appropriate Retirement System on a monthly basis to allow for collection of the premium; and
- c) Develop information and distribute that information to Retired Employees, Annuitants and Survivors related to this Part.

**Section 2200.220 Determining Benefits  
EMERGENCY**

CMS will determine the benefits available to Annuitants, Retired Employees, Survivors and their eligible dependents.

**Section 2200.230 Provision for Benefits  
EMERGENCY**

The Director shall, by contract, self-insurance, or otherwise make available the program of health benefits for Annuitants, Retired Employees, Survivors and their eligible dependents.

**Section 2200.240 Health Insurance Portability and Accountability Act (HIPAA)  
EMERGENCY**

CMS will comply with the uses and disclosures of protected health information, permitted by the Health Insurance Portability and Accountability Act (HIPAA), when applicable as referenced in the plan documents.

**Section 2200.250 Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)  
EMERGENCY**

CMS shall be responsible for compliance with the continuation of benefits requirements of COBRA. All premiums must be collected and transmitted by the respective retirement system.

SUBPART C: RESPONSIBILITIES OF THE APPROPRIATE RETIREMENT SYSTEM

**Section 2200.310 Annuity**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF EMERGENCY RULES

**EMERGENCY**

The Retirement Systems shall report the value of the annuity of each Retired Employee, Annuitant and Survivor to CMS on a monthly basis.

**Section 2200.320 Enrollments and Terminations****EMERGENCY**

The Retirement Systems shall enroll and terminate their respective Retired Employees, Annuitants, Survivors and their dependents pursuant to CMS' policies and procedures and consistent with the terms of the Act.

**Section 2200.330 Premium Collection and Payment****EMERGENCY**

- a) The Retirement Systems shall be responsible for the collection and transmission to CMS of the premium for their respective Retired Employees, Annuitants and Survivors.
- b) Individuals whose annuity check is insufficient to cover the amount of the monthly premiums due pursuant to Subpart E shall be direct billed.

## SUBPART D: VALUE OF ANNUITY

**Section 2200.410 Calculation****EMERGENCY**

- a) The annuity upon which the health insurance premiums are based shall be the gross sum of all annuities received by the Retired Employee, Annuitant or Survivor from the Retirement Systems.
- b) For individuals who retired under PA 93-0839 (between August 16, 2004 and October 31, 2004), PA 94-0109 (between July 1, 2005 and September 30, 2005) or PA 94-0839 (between June 6, 2006 and August 31, 2006), the annuity shall be calculated by SERS and will be equal to the amount of the annuity that would have been received.

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF EMERGENCY RULES

- c) For individuals who retired under the University of Illinois Cooperative Extension Service, the initial annuity shall be the sum of all annuities as provided by each of the Retirement Systems and the US Office of Personnel Management.

## SUBPART E: PREMIUMS

**Section 2200.510 Calculation  
EMERGENCY**

CMS shall calculate the premiums due for the coverage of the Annuitant, Retired Employee or Survivor under this Part as follows:

- a) A percentage of the annuity, as outlined under Section 2200.520; plus
- b) A percentage of cost, as outlined under Section 2200.530.

**Section 2200.520 Percentage of Annuity  
EMERGENCY**

CMS shall calculate the premiums due under this Part as follows:

- a) For each Retired Employee, Annuitant or Survivor with primary coverage under the State program, the premium shall be equal to 2% of the total annual annuity received by the Retired Employee, Annuitant or Survivor from any and all of the five State Retirement Systems;
- b) For each Retired Employee, Annuitant or Survivor with primary coverage under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97), the premium shall be equal to 1% of the total annual annuity received by the Retired Employee, Annuitant or Survivor from any and all of the five State Retirement Systems;
- c) For each Retired Employee, Annuitant or Survivor age 65 or older whose primary coverage would otherwise be coverage under the federal Medicare health insurance program, except for his or her inability to contribute to Medicare while actively working, the premium shall be equal to 1% of the total annual annuity received by the Retired Employee, Annuitant or Survivor from any and all of the five State Retirement Systems.

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF EMERGENCY RULES

**Section 2200.530 Percentage of Cost  
EMERGENCY**

- a) In addition to the percentage of annuity outlined in Section 2200.420, any SERS, SURS or TRS Annuitant who retired on or after January 1, 1998 with less than 20 years of State service, or any SERS, SURS or TRS Survivor whose annuity is based upon the work of an individual who retired on or after January 1, 1998 with less than 20 years of State service, shall pay 5% of the cost of the elected coverage for each year less than 20 upon which the annuity is based.
- b) SURS Annuitants who retired under PA 95-0395, or SURS Survivors whose annuity is based upon the work of an individual who retired under PA 95-0395, shall not be required to pay the additional amounts outlined in subsection (a)(1).

**Section 2200.540 Dependent Premiums  
EMERGENCY**

- a) Annuitants, Retired Employees and Survivors shall be required to pay premiums for any elected dependent coverage in an amount equal to the premiums charged to active employees for elected dependent coverage.
- b) Premiums charged for elected dependent coverage shall be in addition to any premiums due under Sections 2200.520 and 2200.530.

**Section 2200.550 Optional Coverage Premiums  
EMERGENCY**

- a) Annuitants, Retired Employees and Survivors are required to pay premiums for any elected optional coverage, including dental and optional life coverage.
- b) Premiums paid for dental coverage for Annuitants, Retired Employees, Survivors and their enrolled dependents shall be in an amount equal to that paid by active employees.
- c) Premiums paid for optional life insurance coverage for Annuitants, Retired Employees, Survivors and their enrolled dependents shall be in an amount equal to that paid by active employees.

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## NOTICE OF EMERGENCY RULES

- d) Premiums charged for elected optional coverage shall be in addition to any premiums due under Sections 2200.520, 2200.530 and 2200.540.

**Section 220.560 Exempt from Premiums**  
**EMERGENCY**

- a) The following individuals shall not be required to pay premiums due under Section 2200.520 or 2200.530:
- 1) Any person not otherwise covered by the Act who has retired as a participating member under Article 2 of the Code but is ineligible for the retirement annuity under Section 2-119 of the Code;
  - 2) University of Illinois Cooperative Extension retirees whose member basic health premium is paid by the Cooperative Extension Service; and
  - 3) Survivors of employees with less than one year of service.
- b) Individuals receiving benefits under PA 90-0535 (Public Safety Employee Benefit Act) shall not be required to pay premiums due under Section 2200.520, 2200.530 or 2200.540.

JOINT COMMITTEE ON ADMINISTRATIVE RULES  
ILLINOIS GENERAL ASSEMBLY

## SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of June 25, 2013 through July 1, 2013. The rulemakings are scheduled for review at the Committee's July 9, 2013 meeting. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rulemaking should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield IL 62706.

<u>Second Notice Expires</u>	<u>Agency and Rule</u>	<u>Start Of First Notice</u>	<u>JCAR Meeting</u>
8/8/13	<u>Office of the State Fire Marshal</u> , Boiler and Pressure Vessel Safety Act (41 Ill. Adm. Code 120)	4/26/13 37 Ill. Reg. 5279	7/9/13
8/10/13	<u>Department of Healthcare and Family Services</u> , Medical Payment (89 Ill. Adm. Code 140)	12/28/12 36 Ill. Reg. 18105	7/9/13

**ILLINOIS ADMINISTRATIVE CODE**  
**Issue Index - With Effective Dates**

Rules acted upon in Volume 37, Issue 28 are listed in the Issues Index by Title number, Part number, Volume and Issue. Inquiries about the Issue Index may be directed to the Administrative Code Division at (217) 782-7017/18.

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