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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 2014

Issue#	Rules Due Date	Date of Issue
1	December 23, 2013	January 3, 2014
2	December 30, 2013	January 10, 2013
3	January 6, 2014	January 17, 2014
4	January 13, 2014	January 24, 2014
5	January 21, 2014	January 31, 2014
6	January 27, 2014	February 7, 2014
7	February 3, 2014	February 14, 2014
8	February 10, 2014	February 21, 2014
9	February 18, 2014	February 28, 2014
10	February 24, 2014	March 7, 2014
11	March 3, 2014	March 14, 2014
12	March 10, 2014	March 21, 2014
13	March 17, 2014	March 28, 2014
14	March 24, 2014	April 4, 2014
15	March 31, 2014	April 11, 2014
16	April 7, 2014	April 18, 2014
17	April 14, 2014	April 25, 2014
18	April 21, 2014	May 2, 2014

19	April 28, 2014	May 9, 2014
20	May 5, 2014	May 16, 2014
21	May 12, 2014	May 23, 2014
22	May 19, 2014	May 30, 2014
23	May 27, 2014	June 6, 2014
24	June 2, 2014	June 13, 2014
25	June 9, 2014	June 20, 2014
26	June 16, 2014	June 27, 2014
27	June 23, 2014	July 7, 2014
28	June 30, 2014	July 11, 2014
29	July 7, 2014	July 18, 2014
30	July 14, 2014	July 25, 2014
31	July 21, 2014	August 1, 2014
32	July 28, 2014	August 8, 2014
33	August 4, 2014	August 15, 2014
34	August 11, 2014	August 22, 2014
35	August 18, 2014	August 29, 2014
36	August 25, 2014	September 5, 2014
37	September 2, 2014	September 12, 2014
38	September 8, 2014	September 19, 2014
39	September 15, 2014	September 26, 2014
40	September 22, 2014	October 3, 2014
41	September 29, 2014	October 10, 2014
42	October 6, 2014	October 17, 2014
43	October 14, 2014	October 24, 2014
44	October 20, 2014	October 31, 2014
45	October 27, 2014	November 7, 2014
46	November 3, 2014	November 14, 2014
47	November 10, 2014	November 21, 2014
48	November 17, 2014	December 1, 2014
49	November 24, 2014	December 5, 2014
50	December 1, 2014	December 12, 2014
51	December 8, 2014	December 19, 2014
52	December 15, 2014	December 26, 2014

ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

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

<u>Section Numbers:</u>	<u>Proposed Action:</u>
3000.600	Amendment
3000.635	Amendment
- 4) Statutory Authority: Authorized by the Riverboat Gambling Act [230 ILCS 10], specifically subsections 5(c)(2), (3), (7) and (13)
- 5) A Complete Description of the Subjects and Issues Involved: 37 Ill. Reg. 18255 (November 15, 2013) amended Section 3000.100 ("Definitions") and Section 3000.640 ("Exchange of Chips, Tokens, and Vouchers") to authorize the issuance of vouchers at a cashier cage. Before the adoption of that rulemaking, vouchers could be issued only by an electronic gaming device. In order to achieve regulatory consistency, the same authorizations for the issuance of vouchers at a cashier cage must be added to Section 3000.600 ("Wagering Only with Electronic Credits, Approved Chips, Tokens and Electronic Cards") and Section 3000.635 ("Issuance and Use of Tokens and Vouchers for Gaming").
- 6) Published studies and reports, and underlying sources of data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule 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 Objective: 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 rulemaking not later than 45 days after publication of this notice to:

ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

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

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- 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 included on either of the two most recent regulatory agendas because the need for the rulemaking was not anticipated when the agendas were published.

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

ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

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

SUBPART A: GENERAL PROVISIONS

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3000.100	Definitions
3000.101	Invalidity
3000.102	Public Inquiries
3000.103	Organization of the Illinois Gaming Board
3000.104	Rulemaking Procedures
3000.105	Board Meetings
3000.110	Disciplinary Actions
3000.115	Records Retention
3000.120	Place to Submit Materials
3000.130	No Opinion or Approval of the Board
3000.140	Duty to Disclose Changes in Information
3000.141	Applicant/Licensee Disclosure of Agents
3000.150	Owner's and Supplier's Duty to Investigate
3000.155	Investigatory Proceedings
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3000.161	Communication with Other Agencies
3000.165	Participation in Games by Owners, Directors, Officers, Key Persons or Gaming Employees
3000.170	Fair Market Value of Contracts
3000.180	Weapons on Riverboat

SUBPART B: LICENSES

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3000.200	Classification of Licenses
3000.210	Fees and Bonds
3000.220	Applications
3000.221	Other Required Forms
3000.222	Identification and Requirements of Key Persons
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3000.224	Economic Disassociation

ILLINOIS GAMING BOARD

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3000.225	Business Entity and Personal Disclosure Filings
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3000.231	Distributions
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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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3000.241	Renewal of Supplier's License
3000.242	Amendment to Supplier's Product List
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3000.244	Surrender of Supplier's License
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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

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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,

ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

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
3000.425	Proceedings
3000.430	Evidence
3000.431	Prohibition on Ex Parte Communication
3000.435	Sanctions and Penalties
3000.440	Transmittal of Record and Recommendation to the Board
3000.445	Status of Applicant for Licensure or Transfer Upon Filing Request for Hearing

SUBPART E: CRUISING

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3000.500	Riverboat Cruises
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ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

- 3000.636 Distribution of Coupons for Complimentary Chips, Tokens, Vouchers, Cash and Electronic Credits
- 3000.640 Exchange of Chips, Tokens, and Vouchers
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- 3000.660 Minimum Standards for Electronic Gaming Devices
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- 3000.671 Computer Monitoring Requirements of Voucher Systems

SUBPART G: EXCLUSION OF PERSONS

- Section
- 3000.700 Organization of Subpart
- 3000.701 Duty to Exclude
- 3000.705 Voluntary Self-Exclusion Policy (Repealed)
- 3000.710 Distribution and Availability of Board Exclusion List
- 3000.720 Criteria for Exclusion or Ejection and Placement on the Board Exclusion List
- 3000.725 Duty of Licensees
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- 3000.770 Duties of Licensees
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- 3000.782 Required Information, Recommendations, Forms and Interviews
- 3000.785 Appeal of a Notice of Denial of Removal
- 3000.786 Duties of Owner Licensees to Persons Removed from the Self-Exclusion List
- 3000.787 Placement on the Self-Exclusion List Following Removal
- 3000.790 Duties of the Board

ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

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3000.910	Liquor Licenses
3000.920	Disciplinary Action
3000.930	Hours of Sale

SUBPART J: OWNERSHIP AND ACCOUNTING RECORDS AND PROCEDURES

Section

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3000.1010	Accounting Records
3000.1020	Standard Financial and Statistical Records
3000.1030	Annual and Special Audits and Other Reporting Requirements
3000.1040	Accounting Controls Within the Cashier's Cage
3000.1050	Procedures for Exchange of Checks Submitted by Gaming Patrons and Granting Credit
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ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

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3000.1140	Proceedings
3000.1145	Evidence
3000.1146	Prohibition of Ex Parte Communication
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, effective February 15, 2008; amended at 32 Ill. Reg. 3275, effective February 19, 2008; amended

ILLINOIS GAMING BOARD

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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. 12050, effective July 9, 2013; amended at 37 Ill. Reg. 18255, effective November 1, 2013; amended at 38 Ill. Reg. 2808, effective January 8, 2014; amended at 38 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 subsection (b), Riverboat Gaming Wagers may be made only with Electronic Credits, Tokens, 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 at the cashier cage](#), 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:

ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

- 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.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 3000.635 Issuance and Use of Tokens and Vouchers for Gaming

- a) No holder of an Owner's license shall issue or cause to be utilized in a Riverboat Gaming Operation any Tokens for Gaming unless ~~those~~ Tokens are approved by the Administrator. In requesting approval of ~~such~~ Tokens, the holder of an Owner's license shall first submit to the Administrator a detailed schematic of its proposed Token ~~that shows which shall show~~ its front, back and edge, its diameter and thickness, and any logo, design or wording to be contained on the Token, all of which shall be depicted on ~~the~~ schematic as they will appear, both as to size and location, on the actual Token. Once the design schematics are approved by the Administrator, no Token shall be issued or utilized until a sample of ~~the~~ Token is also submitted and approved by the Administrator.
- b) A holder of an Owner's license may, with the approval of the Administrator, issue metal Tokens designed for Gaming. ~~Those~~ Tokens shall:
 - 1) Clearly identify the name and location of the Riverboat Gaming Operation issuing them;
 - 2) Clearly state the face value of the Token;
 - 3) Contain the statement "Not Legal Tender";
 - 4) Not be deceptively similar to any current or past coin of the United States

ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

or a foreign country;

- 5) Be of a size or shape or have other characteristics ~~that~~which will physically prevent their use to activate lawful vending machines or other machines designed to be operated by coins of the United States; and
 - 6) Not be manufactured from a ferromagnetic material or from a three-layered material consisting of a copper-nickel alloy clad on both sides of a pure copper core or from a copper based alloy except if the total zinc, nickel, aluminum, magnesium and other alloying metal exceeds 25 percent of the Token's weight.
- c) Tokens approved for issuance by a holder of an Owner's license shall be:
- 1) Issued to a patron upon payment ~~therefor~~, or in accordance with a complimentary distribution program authorized pursuant to the Act;
 - 2) Capable of insertion into designated Electronic Gaming Devices operated by the holder of an Owner's license for the purpose of activating play;
 - 3) Available as a payout from the hopper of Electronic Gaming Devices equipped with a Token hopper; and
 - 4) Redeemable by the patron in accordance with the Act.
- d) A holder of an Owner's license may, with the prior approval of the Administrator, issue Vouchers through approved Voucher Printers in Electronic Gaming Devices or at the cashier cage. The Vouchers shall:
- 1) Clearly identify the name and location of the Riverboat Gaming Operation issuing them;
 - 2) Clearly identify the specific Electronic Gaming Device or cashier cage location issuing them;
 - 3) Contain a unique validation number, ~~which number~~ or code that shall be automatically generated by or caused to be generated by the Voucher System and not be alterable by any mechanical, electronic, digital or other means prior to issuance;

ILLINOIS GAMING BOARD

NOTICE OF PROPOSED AMENDMENTS

- 4) Clearly state the face value of the Voucher in both words and numbers;
- 5) Contain a date and time of issuance;
- 6) Clearly state a 120 day Redemption Period during which the Voucher may be redeemed at an Electronic Gaming Device, Voucher Validation Terminal or cashier cage of a holder of an Owner's license;
- 7) Be available as a payout from Voucher equipped Electronic Gaming Devices connected to the Voucher System, provided that both the Electronic Gaming Device and the Voucher System are functioning;
- 8) Be individually printed for face values of not less than \$0.01 and not more than \$3,000;
- 9) Contain a bar code ~~that~~^{which} shall enable the Voucher System to access and validate the alpha or numeric information contained in subsections (d)(1) through (6) and display the information when the Voucher is redeemed, provided that only numeric information must be displayed on the System;
- 10) Clearly state that the Voucher may be redeemed for cash at the cashier cage of the holder of an Owner's license for one year from the date of issuance;
- 11) Clearly state the following: "Vouchers issued by another Riverboat may not be used, exchanged or redeemed at this Riverboat.";
- 12) List the unique validation number on the leading edge of each Voucher issued from a Voucher Printer;
- 13) Not be deceptively similar to the currency of the United States or a foreign country;
- 14) Contain at least one anti-counterfeiting measure, such as a unique bar code, ~~that~~^{which} shall appear on one or both sides of the Voucher; and
- 15) Be promptly redeemable by the patron in accordance with this Part.

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- e) Vouchers must be capable of insertion into Voucher equipped Electronic Gaming Devices connected to the Voucher System for the purpose of obtaining Electronic Credits.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Medical Assistance Programs
- 2) Code Citation: 89 Ill. Adm. Code 120
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
120.308	Amendment
120.380	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: Pursuant to PA 98-651, this rulemaking makes changes in the long term application process.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule currently in effect? Yes
- 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>Section Numbers</u> :	<u>Proposed Action</u> :	<u>Illinois Register Citation</u> :
120.324	Amendment	37 Ill. Reg. 12302; August 2, 2013
120.10	Amendment	38 Ill. Reg. 7426; April 4, 2014
120.12	Amendment	38 Ill. Reg. 7426; April 4, 2014
120.32	Amendment	38 Ill. Reg. 7426; April 4, 2014
120.64	Amendment	38 Ill. Reg. 7426; April 4, 2014
- 11) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.
- 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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

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: 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: This rulemaking was not anticipated by the Department when the most recent regulatory agendas were published.

The full text of the Proposed Amendments are identical to the text of the Emergency Rules that appears in this issue of the *Illinois Register* on page 15646.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Covering All Kids Health Insurance Program
- 2) Code Citation: 89 Ill. Adm. Code 123
- 3) Section Number: 123.200 Proposed Action: Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5]
- 5) Complete Description of the Subjects and Issues Involved: Pursuant to PA 98-651, this rulemaking makes changes in eligibility as required by federal law.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule currently in effect? Yes
- 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 Objective: This rulemaking does not affect units of local government.
- 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 East, 3rd Floor
Springfield IL 62763-0002

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HFS.Rules@illinois.gov.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

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: 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: This rulemaking was not anticipated by the Department when the most recent regulatory agendas were published.

The full text of the Proposed Amendment is identical to the text of the Emergency Amendment that appears in this issue of the *Illinois Register* on page 15666:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Medical Payment
- 2) Code Citation: 89 Ill. Adm. Code 140
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
140.80	Amendment
140.82	Amendment
140.84	Amendment
140.86	New Section
140.420	Amendment
140.421	Amendment
140.425	Amendment
140.442	Amendment
140.457	Amendment
140.458	Amendment
140.472	Amendment
140.485	Amendment
140.488	Amendment
140.Table D	Repeal
- 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: This rulemaking implements PA 98-651 and implements procedures related to services provided under the Illinois Medical Assistance program. Included in this rulemaking are the following: changes to the hospital assessment payments, imposition of an assessment upon providers of long-term care facilities serving persons under 22 years of age with clinically complex residents; and the creation of supportive living facility funding. Effective for dates of service on or after July 1, 2014, dental services for adults shall no longer be limited to emergencies. Effective for dates of service on or after October 1, 2014: podiatry services are no longer limited to adults with diabetes; there is no longer a maximum of 20 visits for speech, hearing, and language therapy services, physical therapy services, and occupational therapy services, and all these services shall require prior approval. Further, this rulemaking, effective July 1, 2014, exempts antipsychotics and treatment for certain children with complex medical needs from the prior approval four prescription limit policy.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 7) Will this rulemaking replace any emergency rule currently in effect? Yes
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
140.12	Amendment	37 Ill. Reg. 19971; December 20, 2013
140.440	Amendment	37 Ill. Reg. 19971; December 20, 2013

- 11) Statement of Statewide Policy Objective: This proposed rulemaking neither creates nor expands any State mandate affecting units of local government.
- 12) Time, Place and Manner in which interested persons may comment on the proposed rulemaking:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

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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].

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMSPART 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, 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 PROPOSED 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
- [140.86 Supportive Living Facility Fund](#)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust 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)
- 140.98 Covered Hospital Services (Recodified)
- 140.99 Hospital Services Not Covered (Recodified)
- 140.100 Limitation On Hospital Services (Recodified)
- 140.101 Transplants (Recodified)
- 140.102 Heart Transplants (Recodified)
- 140.103 Liver Transplants (Recodified)
- 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)
- 140.360 Payment Methodology (Recodified)
- 140.361 Non-Participating Hospitals (Recodified)
- 140.362 Pre July 1, 1989 Services (Recodified)
- 140.363 Post June 30, 1989 Services (Recodified)
- 140.364 Prepayment Review (Recodified)
- 140.365 Base Year Costs (Recodified)
- 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)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 140.390 Subacute Alcoholism and Substance Abuse Services (Recodified)
- 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

- Section
- 140.400 Payment to Practitioners
- 140.402 Copayments for Noninstitutional Medical Services
- 140.403 Telehealth Services
- 140.405 Non-Institutional Rate Reductions
- 140.410 Physicians' Services
- 140.411 Covered Services By Physicians
- 140.412 Services Not Covered By Physicians
- 140.413 Limitation on Physician Services
- 140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items – Prescribers
- 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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.436	Limitations on Advanced Practice Nurse Services
140.438	Diagnostic Imaging Services
140.440	Pharmacy Services
140.441	Pharmacy Services Not Covered
140.442	Prior Approval of Prescriptions
140.443	Filling of Prescriptions
140.444	Compounded Prescriptions
140.445	Legend Prescription Items (Not Compounded)
140.446	Over-the-Counter Items
140.447	Reimbursement
140.448	Returned Pharmacy Items
140.449	Payment of Pharmacy Items
140.450	Record Requirements for Pharmacies
140.451	Prospective Drug Review and Patient Counseling
140.452	Mental Health Services
140.453	Definitions
140.454	Types of Mental Health Services
140.455	Payment for Mental Health Services
140.456	Hearings
140.457	Therapy Services
140.458	Prior Approval for Therapy Services
140.459	Payment for Therapy Services
140.460	Clinic Services
140.461	Clinic Participation, Data and Certification Requirements
140.462	Covered Services in Clinics
140.463	Clinic Service Payment
140.464	Hospital-Based and Encounter Rate Clinic Payments
140.465	Speech and Hearing Clinics (Repealed)
140.466	Rural Health Clinics (Repealed)
140.467	Independent Clinics
140.469	Hospice
140.470	Eligible Home Health Care, Nursing and Public Health Providers
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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices
- 140.478 Prior Approval for Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
- 140.479 Limitations, Medical Supplies
- 140.480 Equipment Rental Limitations
- 140.481 Payment for Medical Equipment, Supplies, Prosthetic Devices and Hearing Aids
- 140.482 Family Planning Services
- 140.483 Limitations on Family Planning Services
- 140.484 Payment for Family Planning Services
- 140.485 Healthy Kids Program
- 140.486 Illinois Healthy Women
- 140.487 Healthy Kids Program Timeliness Standards
- 140.488 Periodicity Schedules, Immunizations and Diagnostic Laboratory Procedures
- 140.490 Medical Transportation
- 140.491 Limitations on Medical Transportation
- 140.492 Payment for Medical Transportation
- 140.493 Payment for Helicopter Transportation
- 140.494 Record Requirements for Medical Transportation Services
- 140.495 Psychological Services
- 140.496 Payment for Psychological Services
- 140.497 Hearing Aids
- 140.498 Fingerprint-Based Criminal Background Checks

SUBPART E: GROUP CARE

- Section
- 140.500 Long Term Care Services
- 140.502 Cessation of Payment at Federal Direction
- 140.503 Cessation of Payment for Improper Level of Care
- 140.504 Cessation of Payment Because of Termination of Facility
- 140.505 Informal Hearing Process for Denial of Payment for New ICF/MR
- 140.506 Provider Voluntary Withdrawal
- 140.507 Continuation of Provider Agreement
- 140.510 Determination of Need for Group Care
- 140.511 Long Term Care Services Covered By Department Payment
- 140.512 Utilization Control
- 140.513 Notification of Change in Resident Status
- 140.514 Certifications and Recertifications of Care (Repealed)
- 140.515 Management of Recipient Funds – Personal Allowance Funds

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.516	Recipient Management of Funds
140.517	Correspondent Management of Funds
140.518	Facility Management of Funds
140.519	Use or Accumulation of Funds
140.520	Management of Recipient Funds – Local Office Responsibility
140.521	Room and Board Accounts
140.522	Reconciliation of Recipient Funds
140.523	Bed Reserves
140.524	Cessation of Payment Due to Loss of License
140.525	Quality Incentive Program (QUIP) Payment Levels
140.526	County Contribution to Medicaid Reimbursement (Repealed)
140.527	Quality Incentive Survey (Repealed)
140.528	Payment of Quality Incentive (Repealed)
140.529	Reviews (Repealed)
140.530	Basis of Payment for Long Term Care Services
140.531	General Service Costs
140.532	Health Care Costs
140.533	General Administration Costs
140.534	Ownership Costs
140.535	Costs for Interest, Taxes and Rent
140.536	Organization and Pre-Operating Costs
140.537	Payments to Related Organizations
140.538	Special Costs
140.539	Reimbursement for Basic Nursing Assistant, Developmental Disabilities Aide, Basic Child Care Aide and Habilitation Aide Training and Nursing Assistant Competency Evaluation
140.540	Costs Associated With Nursing Home Care Reform Act and Implementing Regulations
140.541	Salaries Paid to Owners or Related Parties
140.542	Cost Reports – Filing Requirements
140.543	Time Standards for Filing Cost Reports
140.544	Access to Cost Reports (Repealed)
140.545	Penalty for Failure to File Cost Reports
140.550	Update of Operating Costs
140.551	General Service Costs Updates
140.552	Nursing and Program Costs
140.553	General Administrative Costs Updates
140.554	Component Inflation Index (Repealed)
140.555	Minimum Wage

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 140.560 Components of the Base Rate Determination
- 140.561 Support Costs Components
- 140.562 Nursing Costs
- 140.563 Capital Costs
- 140.565 Kosher Kitchen Reimbursement
- 140.566 Out-of-State Placement
- 140.567 Level II Incentive Payments (Repealed)
- 140.568 Duration of Incentive Payments (Repealed)
- 140.569 Clients With Exceptional Care Needs
- 140.570 Capital Rate Component Determination
- 140.571 Capital Rate Calculation
- 140.572 Total Capital Rate
- 140.573 Other Capital Provisions
- 140.574 Capital Rates for Rented Facilities
- 140.575 Newly Constructed Facilities (Repealed)
- 140.576 Renovations (Repealed)
- 140.577 Capital Costs for Rented Facilities (Renumbered)
- 140.578 Property Taxes
- 140.579 Specialized Living Centers
- 140.580 Mandated Capital Improvements (Repealed)
- 140.581 Qualifying as Mandated Capital Improvement (Repealed)
- 140.582 Cost Adjustments
- 140.583 Campus Facilities
- 140.584 Illinois Municipal Retirement Fund (IMRF)
- 140.590 Audit and Record Requirements
- 140.642 Screening Assessment for Nursing Facility and Alternative Residential Settings and Services
- 140.643 In-Home Care Program
- 140.645 Home and Community Based Services Waivers for Medically Fragile, Technology Dependent, Disabled Persons Under Age 21 (Repealed)
- 140.646 Reimbursement for Developmental Training (DT) Services for Individuals With Developmental Disabilities Who Reside in Long Term Care (ICF and SNF) and Residential (ICF/MR) Facilities
- 140.647 Description of Developmental Training (DT) Services
- 140.648 Determination of the Amount of Reimbursement for Developmental Training (DT) Programs
- 140.649 Effective Dates of Reimbursement for Developmental Training (DT) Programs
- 140.650 Certification of Developmental Training (DT) Programs
- 140.651 Decertification of Day Programs

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.652	Terms of Assurances and Contracts
140.680	Effective Date Of Payment Rate
140.700	Discharge of Long Term Care Residents
140.830	Appeals of Rate Determinations
140.835	Determination of Cap on Payments for Long Term Care (Repealed)

SUBPART F: FEDERAL CLAIMING FOR STATE AND
LOCAL GOVERNMENTAL ENTITIES

Section

140.850	Reimbursement of Administrative Expenditures
140.855	Administrative Claim Review and Reconsideration Procedure
140.860	County Owned or Operated Nursing Facilities
140.865	Sponsor Qualifications (Repealed)
140.870	Sponsor Responsibilities (Repealed)
140.875	Department Responsibilities (Repealed)
140.880	Provider Qualifications (Repealed)
140.885	Provider Responsibilities (Repealed)
140.890	Payment Methodology (Repealed)
140.895	Contract Monitoring (Repealed)
140.896	Reimbursement For Program Costs (Active Treatment) For Clients in Long Term Care Facilities For the Developmentally Disabled (Recodified)
140.900	Reimbursement For Nursing Costs For Geriatric Residents in Group Care Facilities (Recodified)
140.901	Functional Areas of Needs (Recodified)
140.902	Service Needs (Recodified)
140.903	Definitions (Recodified)
140.904	Times and Staff Levels (Repealed)
140.905	Statewide Rates (Repealed)
140.906	Reconsiderations (Recodified)
140.907	Midnight Census Report (Recodified)
140.908	Times and Staff Levels (Recodified)
140.909	Statewide Rates (Recodified)
140.910	Referrals (Recodified)
140.911	Basic Rehabilitation Aide Training Program (Recodified)
140.912	Interim Nursing Rates (Recodified)

SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section	
140.920	General Description
140.922	Covered Services
140.924	Maternal and Child Health Provider Participation Requirements
140.926	Client Eligibility (Repealed)
140.928	Client Enrollment and Program Components (Repealed)
140.930	Reimbursement
140.932	Payment Authorization for Referrals (Repealed)

SUBPART H: ILLINOIS COMPETITIVE ACCESS AND
REIMBURSEMENT EQUITY (ICARE) PROGRAM

Section	
140.940	Illinois Competitive Access and Reimbursement Equity (ICARE) Program (Recodified)
140.942	Definition of Terms (Recodified)
140.944	Notification of Negotiations (Recodified)
140.946	Hospital Participation in ICARE Program Negotiations (Recodified)
140.948	Negotiation Procedures (Recodified)
140.950	Factors Considered in Awarding ICARE Contracts (Recodified)
140.952	Closing an ICARE Area (Recodified)
140.954	Administrative Review (Recodified)
140.956	Payments to Contracting Hospitals (Recodified)
140.958	Admitting and Clinical Privileges (Recodified)
140.960	Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Recodified)
140.962	Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Recodified)
140.964	Contract Monitoring (Recodified)
140.966	Transfer of Recipients (Recodified)
140.968	Validity of Contracts (Recodified)
140.970	Termination of ICARE Contracts (Recodified)
140.972	Hospital Services Procurement Advisory Board (Recodified)
140.980	Elimination Of Aid To The Medically Indigent (AMI) Program (Emergency Expired)
140.982	Elimination Of Hospital Services For Persons Age Eighteen (18) And Older And Persons Married And Living With Spouse, Regardless Of Age (Emergency Expired)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

SUBPART I: PRIMARY CARE CASE MANAGEMENT PROGRAM

Section

140.990	Primary Care Case Management Program
140.991	Primary Care Provider Participation Requirements
140.992	Populations Eligible to Participate in the Primary Care Case Management Program
140.993	Care Management Fees
140.994	Panel Size and Affiliated Providers
140.995	Mandatory Enrollment
140.996	Access to Health Care Services
140.997	Payment for Services

SUBPART J: ALTERNATE PAYEE PARTICIPATION

Section

140.1001	Registration Conditions for Alternate Payees
140.1002	Participation Requirements for Alternate Payees
140.1003	Recovery of Money for Alternate Payees
140.1004	Conditional Registration for Alternate Payees
140.1005	Revocation of an Alternate Payee

SUBPART K: MANDATORY MCO ENROLLMENT

140.1010	Mandatory Enrollment in MCOs
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SUBPART L: UNAUTHORIZED USE OF MEDICAL ASSISTANCE

Section

140.1300	Definitions
140.1310	Recovery of Money
140.1320	Penalties
140.1330	Enforcement
140.TABLE A	Criteria for Non-Emergency Ambulance Transportation
140.TABLE B	Geographic Areas
140.TABLE C	Capital Cost Areas
140.TABLE D	Schedule of Dental Procedures (Repealed)
140.TABLE E	Time Limits for Processing of Prior Approval Requests

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.TABLE F	Podiatry Service Schedule (Repealed)
140.TABLE G	Travel Distance Standards
140.TABLE H	Areas of Major Life Activity
140.TABLE I	Staff Time and Allocation for Training Programs (Recodified)
140.TABLE J	HSA Grouping (Repealed)
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 and VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and 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; peremptory 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; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory 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

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December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a 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

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B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 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,

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effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; 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.

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Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment 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

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22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective 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

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October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective 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 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; peremptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; peremptory 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; peremptory amendment repealed by emergency

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rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days; 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; amended at 37 Ill. Reg. 12855, effective July 24, 2013; emergency amendment at 37 Ill. Reg. 14196, effective August

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20, 2013, for a maximum of 150 days; amended at 37 Ill. Reg. 17584, effective October 23, 2013; amended at 37 Ill. Reg. 18275, effective November 4, 2013; amended at 37 Ill. Reg. 20339, effective December 9, 2013; amended at 38 Ill. Reg. 859, effective December 23, 2013; emergency amendment at 38 Ill. Reg. 1174, effective January 1, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. 4330, effective January 29, 2014; amended at 38 Ill. Reg. 7156, effective March 13, 2014; amended at 38 Ill. Reg. 12141, effective May 30, 2014; emergency amendment at 38 Ill. Reg. 15673, effective July 7, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. _____, effective _____.

SUBPART C: PROVIDER ASSESSMENTS

Section 140.80 Hospital Provider Fund

- a) Purpose and Contents
 - 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 Article 5A of the Code.
 - 3) The Fund shall consist of:
 - A) All monies collected or received by the Department under subsection (b);
 - 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.

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b) Provider Assessments

- 1) Subject to Sections 5A-3, 5A-10 and 5A-15 of the Public Aid Code, for State fiscal years 2009 through ~~2018~~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; provided, however, the amount of \$218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the State share of the payments authorized under Section 12-5 of the Public Aid Code, with that increase only taking effect upon the date that a State share for those payments is required under federal law. For State fiscal years 2009 through 2014 and ~~after, 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 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 Sections 5A-3, 5A-10, and 5A-15 of the Public Aid Code for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through ~~2018~~2014, and the portion of State fiscal year 2015 that ends December 31, 2014, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue; provided, however, the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 12-5, with that increase only taking effect upon the date that a State share for those payments is required under federal law. For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years

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2013 through ~~2018~~2014, and the portion of State fiscal year 2015 that ends ~~December 31, 2014~~, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to ~~that such~~ data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross 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. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days.

c) Payment of Assessment Due

- 1) The inpatient assessment imposed by Section 5A-2 of the Code 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 14th State business day of each month. No installment payments of an inpatient assessment shall be due and payable, however, until after the Comptroller has issued the payments required under Section 5A-12.2 of the Code. Assessment payments postmarked on the due date will be considered as paid on time.
- 2) Except as provided in Section 5A-4(a-5) of the Code, the outpatient assessment imposed by subsection (b)(2) of this Section for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal year 2013 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 14th State business day of each month.
 - A) No installment payment of an outpatient assessment imposed by subsection (b)(2) shall be due and payable, however, until after:
 - i) the Department notifies the hospital provider, in writing,

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that the payment methodologies to hospitals required under Section 5A-12.4 of the Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (CMMS), and the waiver under 42 CFR 433.68 for the assessment imposed by subsection (b)(4) of this Section, if necessary, has been granted by CMMS; and

- ii) the Comptroller has issued the payments required under Section 5A-12.4 of the Code.
- B) 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 required under Section 5A-12.4 of the Code and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under subsection (b)(2) of this Section prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.4 of the Code.
- 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), except that no notice shall be sent for the outpatient assessment imposed under subsection (b)(2) until the Department receives written notice that the payment methodologies to hospitals required under Section 5A-12.4 of the

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Code has been approved and the waiver under 42 CFR 433.68, if necessary, has been granted by CMMS.

- 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), the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) 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).
 - 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), upon notice by the Department, shall pay the assessment under subsection (d) 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 2009 through ~~2018~~~~2015~~, in the case of a hospital provider that did not conduct, operate or maintain a hospital in 2005, the inpatient 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. For the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 ~~through 2018 and 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 2009, the outpatient assessment imposed under subsection (b)(2) shall be computed on the basis of hypothetical gross outpatient revenue for the full calendar year as

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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 for the portion of the reporting period the hospital was operational (dividing the assessment due by the number of days the hospital was in operation and then multiplying the amount by 365). 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 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).

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% of the amount of the installment not paid on or before the due date, plus 5% of the portion 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

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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 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) 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

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- 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), 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). 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 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) would impose severe and irreparable harm to the clients served. Circumstances that may create these 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:

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- 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)(~~2~~)(~~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).
 - iii) A hospital that has filed for Chapter 11 bankruptcy and that meets the cash flow criterion under subsection (h)(1)(A)(ii).
- C) The provider must ensure that a delay of payment request, as defined under subsection (h)(3)(A), 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.

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- 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) that shall be due from the provider as a result of institution of the delayed 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) 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,

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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 [Hospital and Provider Services 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 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), a denial of application to borrow the assessment as defined in subsection (h)(1)(D) 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) 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

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Department has received the signed agreement in accordance with subsection (h)(3)(B), the 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 the 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). The interest may be waived by the Department if the facility's current ratio, as described in subsection (h)(1)(C), is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B). Any waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E).
- 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) 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 5A-1, 2, 3, 4, 5, 7, 8, 10 and 12 of the Code and collect the assessments and penalty assessments imposed under Sections 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 5A-1, 2, 3, 4, 5, 7, 8, 10 and 12 of the Code. Administrative enforcement proceedings initiated shall be

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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 5A-2 of the Code shall 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 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 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 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 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 5A-2, 4 and 5 of the Code.
- 4) Payments under Section 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

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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 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.
 - 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.
- k) Nothing in Section 5A-4 of the Code 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) "CMMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.
 - 2) "Department" means the Illinois Department of Healthcare and Family Services.
 - 3) "Fund" means the Hospital Provider Fund.
 - 4) "HCRIS" means the federal Centers for Medicare and Medicaid Services Healthcare Cost Report Information System.
 - 5) "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.
 - 6) "Hospital Provider" means a person licensed by the Department of Public

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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.

- 7) "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.
 - 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.
- 8) "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

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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.

- 9) "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.
 - 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.
- 10) "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).
- 11) "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.

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Occupied bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

- 12) "Outpatient Gross Revenue" means, for each hospital, its total gross charges attributed to outpatient services as reported on the Medicare cost report at 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 38 Ill. Reg. _____, effective _____)

Section 140.82 Developmentally Disabled Care Provider Fund

a) Purpose and Contents

- 1) The Developmentally Disabled Care Provider Fund was created in the State Treasury on July 1, 1992, July 14, 1993 and July 1, 1995 (see 305 ILCS 5/5C-7). 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 5/5C-2 and 7 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) All other monies received for the Fund from any other source, including interest earned thereon; and

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- E) All monies transferred from the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund.

b) Provider Assessments

- 1) Beginning on July 1, 1993, an assessment is imposed upon each developmentally disabled care provider in an amount equal to ~~6%~~^{six} percent, or the maximum allowed under federal regulation, whichever is less, of its adjusted gross developmentally disabled care revenue for the prior State fiscal year. The revenue for each year will be reported on the Developmentally Disabled Care Provider Tax form to be filed by a date designated by the Department. The Department reserves the right to audit the reported data.
- 2) Effective July 1, 2013, for the privilege of engaging in the occupation of long term care facility for persons under 22 years of age serving clinically complex residents provider, an assessment is imposed upon each long term care facility for persons under 22 years of age serving clinically complex residents in the same amount and upon the same conditions and requirements as imposed in Section 140.84 and a license fee is imposed in the same amount and upon the same conditions and requirements as imposed in Section 140.84. Notwithstanding any provision of any other Act to the contrary, the assessment and license fee imposed by this subsection (b)(2) shall be construed as a tax, but may not be added to the charges of an individual's nursing home care that is paid for in whole, or in part, by a federal, State, or combined federal-State medical care program, except for those individuals receiving Medicare Part B benefits solely.

c) Payment of Assessment Due

- 1) The assessment described in subsection (b) ~~of this Section~~ shall be due and payable in quarterly installments, each equaling one-fourth of the assessment for the year, on September 30, December 31, March 31, and May 31 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the due dates. Assessment payments postmarked on the due date will be considered paid on time.
- 2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the

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most delinquent installments.

- d) Reporting Requirements, Penalty, and Maintenance of Records
- 1) After June 30 of each State fiscal year, and on or before September 30 of the succeeding State fiscal year, every developmentally disabled care provider subject to an assessment under subsection (b) ~~of this Section~~ shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross developmentally disabled care revenue from the State fiscal year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the preceding July 1. If a developmentally disabled care provider operates or maintains more than one developmentally disabled care facility, a separate report shall be filed for each facility. In the case of a developmentally disabled care provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.
 - 2) If the developmentally disabled care provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the assessment imposed in subsection (b) ~~of this Section~~ a penalty assessment equal to 25 percent of the assessment imposed for the year.
 - 3) Every developmentally disabled care provider subject to an assessment under subsection (b) ~~of this Section~~ shall keep records and books that will permit the determination of adjusted gross developmentally disabled care revenue on a State fiscal year basis. All such books and records shall be maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.
 - 4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with ~~subsections subsection~~ (d)(5) or (6) ~~of this Section~~, an amended assessment report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the

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justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

- 5) Submission of Financial Audit Statements. All developmentally disabled care providers are required to submit a copy of all financial statements audited by an external, independent auditor to the Department within 30 days after the close of ~~thesueh~~ externally performed financial audits. If the provider's year end does not coincide with the June 30 ending date for the assessment report, the provider must submit all financial audits covering the tax report period. An amended assessment report must accompany ~~thesueh~~ external financial audit statements if the data submitted on the initial tax report changes based upon the findings of ~~thesueh~~ external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.
 - 6) Reconsideration of Adjusted Tax. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a developmentally disabled care provider, the developmentally disabled care provider may request a review or reconsideration of the adjusted assessment within 30 days after the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if ~~thosesueh~~ requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.
- e) Procedure for Partial Year Reporting/Operating Adjustments
- 1) Cessation of business during the fiscal year in which the assessment is being paid. For a developmentally disabled care provider who ceases to conduct, operate, or maintain a facility 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 months in the year during which the provider conducts, operates, or maintains the facility and

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the denominator of which is 12. The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and shall pay with the final report the assessment for the year as so adjusted, to the extent not previously paid.

- 2) Commencing of business during the fiscal year in which the assessment is being paid. A developmentally disabled care provider who commences conducting, operating, or maintaining a facility for which the person is subject to assessment under subsection (b) ~~of this Section~~ shall file an initial return for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (d) ~~of this Section~~ as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.
- 3) Partial Fiscal Year Operation Adjustment. For a developmentally disabled care provider that did not conduct, operate, or maintain a facility throughout the entire fiscal year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual developmentally disabled care revenue for the portion of the reporting period the facility was operational (dividing adjusted developmentally disabled care revenue by the number of months the facility was in operation and then multiplying that amount by 12). Developmentally disabled care revenue realized by a prior provider from the same facility during the fiscal year shall be used in the annualization equation, if available.
- 4) Change in Ownership and/or Operators. The full quarterly assessment 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 developmentally disabled care provider currently operating or maintaining the developmentally disabled care facility regardless if these amounts were

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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 facility 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 five percent of the amount of the installment not paid on or before the due date, plus 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. Reasonable cause may include but is not limited to:
 - A) a provider who has not been delinquent on payment of an assessment due within the last three calendar years from the time the delinquency occurs;
 - B) a provider who can demonstrate to the Department's satisfaction that a payment was made prior to the due date; or
 - C) that the 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 facilities participating in the Medicaid Program. Payments may be withheld from the facility until the entire provider assessment, including any penalties, is satisfied, or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if the facility 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 provider's future payments from the Department. The provider may appeal this recoupment in accordance with the Department's rules at 89 Ill. Adm. Code 104. The Department has the

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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 facility two times in a fiscal year may be cause for termination from the 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 facility 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 of the assessment 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 Facilities

The Department may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of facilities when:

- 1) the State delays payments to facilities 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 facilities will be unable to obtain a loan to pay the assessment.

h) Delayed Payment – Individual Facilities

In addition to the provisions of subsection (g) ~~of this Section~~, the Department may delay assessments for individual facilities 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 date of the assessment.

- 1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

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- A) the facility has experienced an emergency which 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), (f)(2) and (f)(3) ~~of this Section~~ would impose severe and irreparable harm to the clients served. Circumstances that may create such 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 facility's ability to provide further services to clients is severely impaired;
 - ii) cash flow problems encountered by a facility 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 facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:
- i) 85 percent or more of their residents must be eligible for public assistance;
 - ii) a government-owned facility, that meets the cash flow criteria under subsection (h)(1)(A)(ii) ~~of this Section~~.
 - iii) a provider who has filed for Chapter 11 bankruptcy that meets the cash flow criterion under subsection (h)(1)(A)(ii) ~~of this Section~~.
- C) the facility must ensure that a delay of payment request, as defined in 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

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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;
 - iii) cash or other assets have been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.
- D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow the 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 facility 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

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- subsection (h)(5) ~~of this Section~~ that shall be due from the facility as a result of institution of the delayed 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) such other terms and conditions that may be required by the Department.
- 2) A facility that does not meet the criteria listed in subsection (h)(1) may request a delayed payment schedule. The Department may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. 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, facilities must ensure that 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 due date designated by the Department. Providers will be notified, in writing, of 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:

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- i) an explanation of the circumstances creating the need for the delayed payment provisions;
 - ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and
 - iii) specification of the specific arrangements requested by the facility.
 - B) The facility 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 facility for all approved requests. The agreement must be signed by the administrator, owner 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 facility's request for institution of delayed payment provisions. In the event a facility'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~~, ~~thesuch~~ penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and ~~thesuch~~ 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 facility meets the criteria in subsections (h)(1)(A) and (B) ~~of this Section~~. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) ~~of this Section~~.

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- 6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility 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 delay of payment agreement. The waiver of penalties described in subsection (h)(4) ~~of this Section~~ shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.
- i) Administration and Enforcement Provisions
The Department shall administer and enforce ~~Section 305 ILCS 5/5C-6~~ of the Code and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of ~~the~~this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").
- j) Nothing in ~~Section 305 ILCS 5/5C~~ of the Code shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before July 1, 1995.
- k) Definitions
- 1) "Adjusted gross developmentally disabled care revenue" means the developmentally disabled care provider's total revenue for inpatient residential services, less contractual allowances and discounts on patients' accounts, but does not include non-patient revenue from sources such as contributions, donations or bequests, investments, day training services, television and telephone service, rental of facility space, or sheltered care revenue. Adjusted gross developmentally disabled care revenue must be reported on an accrual basis for the tax reporting period. All patient revenue accrued during the tax reporting period must be included even though reimbursement may occur after the tax reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the facility's last two cost reports.
- 2) "Contractual Allowance" means the difference between charges at

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established rates and the amount estimated to be paid by third party payors or patients, as appropriate, pursuant to agreements/contracts with the developmentally disabled care provider; courtesy and policy discounts provided to employees, medical staff and clergy; and charity care, but "contractual allowance" does not mean any Provider Participation fees/taxes paid to the Department.

- 3) "Department" means the Illinois Department of Healthcare and Family Services.
- 4) "Developmentally disabled care facility" means an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.
- 5) "Developmentally disabled care provider" means a person conducting, operating, or maintaining a developmentally disabled care facility. For this purpose, "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.
- 6) "Facility" means all intermediate care facilities as defined under "~~developmentally~~Developmentally disabled care facility" ([see](#) subsection (k)(4)).
- 7) "Fund" means the Developmentally Disabled Care Provider Fund.
- 8) "[Long term care facility for persons under 22 years of age serving clinically complex residents](#)" means a facility licensed by the Department of Public Health as a long term care facility for persons under 22 meeting the qualifications of [Section 5.4h of the Code](#).

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.84 Long Term Care Provider Fund

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- a) Purpose and Contents
- 1) The Long Term Care Provider Fund was created in the State Treasury on July 1, 1992, July 14, 1993 and July 1, 1995 (see [Section 305 ILCS 5/5B-8 of the Code](#)). 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 5/5B-2 and 8 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) All other monies received for the Fund from any other source, including interest earned thereon; and
 - E) All monies transferred from the Tobacco Products Tax Act [\[35 ILCS 143\]](#).
- b) License Fee and Provider Assessment
- Beginning on July 1, 1993, a nursing home license fee is imposed upon each nursing home provider in an amount equal to \$1.50 for each licensed nursing bed day for the calendar quarter in which the payment is due. All nursing beds subject to licensure under the Nursing Home Care Act or the Hospital Licensing Act, with the exception of swing-beds, as defined in subsection (k)(8) ~~of this Section~~ will be used to calculate the licensed nursing bed days for each quarter. This license fee shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider. Changes in the number of licensed nursing beds will be

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reported to the Department quarterly, as described in subsection (d)(1) ~~of this Section~~. The Department reserves the right to audit the reported data. Beginning July 1, 2011, an assessment is imposed upon each long term care provider in an amount equal to \$6.07 times the number of occupied bed days due and payable each month. This assessment shall be construed as a tax, but shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider.

c) Payment of License Fee and Assessment Due

- 1) The license fee described in subsection (b) ~~of this Section~~ shall be due and payable in quarterly installments, on September 10, December 10, March 10, and June 10 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the quarterly due dates. License fee payments postmarked on the due date will be considered as paid on time.
- 2) The assessment described in subsection (b) ~~of this Section~~ shall be due and payable monthly, on the last State business day of the month for occupied bed days reported for the preceding third month prior to the month in which the tax is payable and due. A facility that has its payments from the State delayed, due to problems related to State cash flow, may request an extension on the due date for payment pursuant to subsection (b) ~~of this Section~~ and shall pay each extended assessment payment within 30 days after each reimbursement for services by the Department.
 - A) The Department shall provide for an electronic submission process for each long term care facility to report the number of occupied bed days of the long term care facility for the reporting period and other reasonable information the Department requires for the administration of its responsibilities. To the extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of long term care facilities.
 - B) Beginning July 1, 2013, a separate electronic submission shall be completed for each long term care facility in this State operated by a long term care provider. The Department shall prepare an assessment, based on the reported occupied beds, and will bill the facility stating the amount due and payable each month and submit

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it to each long term care facility via an electronic process. Each assessment payment shall be accompanied by a copy of the assessment bill sent to the long term care facility by the Department.

- C) The provider assessment imposed by this Section shall not be due and payable until after the Department notifies the long term care providers, in writing, that the payment methodologies to long term care providers required under Section 5-5.4 of the Public Aid Code have been approved and the waivers under 42 CFR 433.68, if necessary, have been granted by ~~CMMSthe Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.~~

- 3) 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.
- 4) County nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code [\[55 ILCS 5\]](#) may meet their license fee or assessment obligation by the county government certifying to the Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the license fee or assessment. County governments wishing to provide such certification must:
- A) Sign a certification form certifying that the funds represent expenditures eligible for federal financial participation under Title XIX of the Social Security Act (42 USC 1396), and that these funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds;
- B) Submit the certification document to the Department once a year along with a copy of that portion of the county budget showing the funds appropriated for the operation of the county nursing home. These documents must be submitted within 30 days after the final approval of the county budget;
- C) Submit the monthly claim form in the amount of the rate

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established by the Department minus any third party liability amount. This amount will be reduced by an amount determined by the amount certified and the number of months remaining in the fiscal year, prior to payment because a certification statement was provided in lieu of an actual license fee or assessment payment; and

- D) Make records available upon request to the Department and/or the United States Department of Health and Human Services pertaining to the certification of county funds.
- d) Reporting Requirements, Penalty, and Maintenance of Records
- 1) On or before the due dates described in subsection (c)(1) ~~of this Section~~, each nursing home provider subject to a license fee under subsection (b) ~~of this Section~~ shall file a report with the Department reflecting any changes in the number of licensed nursing beds occurring during the reporting quarter. The report shall be on a form prepared by the Department. The changes will be reported quarterly and shall be submitted with the revised quarterly license fee payment. For the purpose of calculating the license fee described in subsection (b) ~~of this Section~~, all changes in licensed nursing beds will be effective upon approval of the change by the Illinois Department of Public Health. Documentation showing the change in licensed nursing beds, and the date the change was approved by the Illinois Department of Public Health, must be submitted to the Department of Healthcare and Family Services with the licensed nursing bed change form.
 - 2) After December 31 of each year, and on or before March 31 of the succeeding year, every long term care provider subject to assessment under subsection (c)(2) ~~of this Section~~ shall file a report with the Department. The report shall be in a form and manner prescribed by the Department and shall state the revenue received by the long term care provider, reported in such categories as may be required by the Department, and other reasonable information the Department requires for the administration of its responsibilities.
 - 3) If a provider operates or maintains more than one nursing home, a separate report shall be filed for each facility. In the case of a provider existing as

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a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice president, secretary or treasurer or by its properly authorized agent.

- 4) If the provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the license fee or assessment imposed in subsection (b) ~~of this Section~~ a penalty fee equal to 25% ~~percent~~ of the assessment or license fee imposed for the year. After July 1, 2013, no penalty will be assessed if the Department has not established a process for the electronic submission of information as it pertains to the assessment.
- 5) Every provider subject to a license fee or assessment under subsection (b) ~~of this Section~~ shall keep records and books that will permit the determination of licensed nursing bed days on a quarterly basis and occupied beds on a monthly basis. All such books and records shall be maintained for a minimum of three years following the filing date of each report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.
- 6) Amended License Fee and Assessment Reports. With the exception of amended license fee or assessment reports filed in accordance with this subsection (d)(6), an amended license fee report or monthly assessment report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual license fee or assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.
- 7) Reconsideration of Adjusted License Fee or Assessment. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the license fee or assessment was due, changes the license fee or assessment liability of a provider, the provider may request a review or reconsideration of the adjusted license fee or assessment within 30 days after the Department's notification of the change in license fee or assessment liability. Requests for reconsideration of the license fee or assessment adjustment shall not be

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considered if those requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

- e) Procedure for Partial Year Reporting/Operating Adjustments
- 1) Cessation of business during the period in which the license fee or assessment is being paid and the closure date has been set. A provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee or assessment imposed under subsection (b) of this Section, and for which the closure date for the facility has been set, shall file a final report with the Department on or before the due date for the period in which the closure is to occur. The report will reflect the adjusted number of days the facility is open during the reporting period and shall be submitted with the final quarterly license fee or monthly assessment payment. Example: A facility is set to close on September 24. On or before the due date for the reporting quarter of July 1 through September 30, the facility will submit a final report reflecting 86 days of operation (July 1 through September 24) and the corresponding quarterly license fee payment.
 - 2) Cessation of business after the monthly or quarterly due date. A provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee or assessment imposed under subsection (b) ~~of this Section~~, and for which closure occurs after the due date for the reporting period, but prior to the last day of the reporting period, shall file an amended final report with the Department within 30 days after the closure date. The amended report will reflect the number of days the facility was operational during the reporting period and the revised license fee or assessment amount. Upon verifying the data submitted on the amended report, the Department will issue a refund for the amount overpaid. Example: On December 10 a facility pays the license fee for 92 days covering the reporting quarter of October 1 through December 31. The facility closes on December 27. An amended report reflecting 88 days, the actual number of days the facility was operational during the quarter (October 1 through December 27) must be filed with the Department.
 - 3) Cessation of business prior to the monthly or quarterly due date. A

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provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee or assessment imposed under subsection (b) ~~of this Section~~, and for which closure occurs prior to the due date for the reporting period, shall file a final report with the Department within 30 days after the closure date. The final report will reflect the number of days the facility was operational during the reporting period and the corresponding final license fee and assessment amount. Closure dates will be verified with the Department of Public Health, and if necessary adjustments will be made to the final license fee and assessment due. Example: Facility closes on January 17. On or before February 17, the facility must file a final report for the reporting quarter of January 1 through March 31. The report would reflect 17 days of operation (January 1 through January 17) during the quarter and must be accompanied by the final license fee payment for the facility.

- 4) Commencing of business during the fiscal year in which the license fee or assessment is being paid. A provider who commences conducting, operating, or maintaining a facility for which the person is subject to the license fee or assessment imposed under subsection (b) ~~of this Section~~ shall file an initial report for the reporting period in which the commencement occurs within 30 calendar days thereafter and shall pay the license fee and assessment under subsection (c) ~~of this Section~~. In determining the annual assessment amount for the provider, the Department shall develop hypothetical annualized occupied bed projections based upon geographic location and facility. The assessment determination made by the Department is final.
- 5) Change in Ownership and/or Operators. The full monthly/quarterly assessment/license fee must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment/license fee amount (including past due assessment/license fees and any interest or penalties that may have accrued against the amount) rests on the provider currently operating or maintaining the nursing facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment/license fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment/license fee liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) ~~of this Section~~.

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- 6) Upon request, the Department will share with a potential buyer of a facility information on outstanding assessments and penalties owed by that facility.
- f) Penalties
- 1) Any provider that fails to pay the full amount of a license fee or assessment when due, or fails to report a change in licensed nursing beds approved by the Department of Public Health prior to the due date of the license fee or assessment, shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent of the amount of the license fee or assessment not paid on or before the due date, plus 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 or assessment amount not paid on or before the due date. Reasonable cause may include but is not limited to:
 - A) a provider who has not been delinquent on payment of a license fee or assessment due, within the last three calendar years from the time the delinquency occurs;
 - B) a provider who can demonstrate to the Department's satisfaction that a payment was made prior to the due date; or
 - C) that the provider is a new owner/operator and the late payment occurred in the reporting period 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 providers participating in the Medicaid Program. Payments may be withheld from the provider until the entire license fee or assessment, including any 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 provider fails to comply with an agreement, the Department reserves the right to recover any outstanding license fee, assessment, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with

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the 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 provider two times in a fiscal year may be cause for termination from the 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 provider 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 license fee or assessment 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 Facilities

The Department may establish delayed payment of fees/assessment and/or waive the payment of interest and penalties for groups of facilities when:

- 1) the State delays payments to facilities 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 facilities will be unable to obtain a loan to pay the license fee.

h) Delayed Payment – Individual Facilities

In addition to the provisions of subsection (g) ~~of this Section~~, the Department may delay license fees or assessments for individual facilities 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 period or month following the quarter in which the license fee or the assessment payment was to have been received by the Department as described in subsection (c) ~~of this Section~~. The Department may not deny a request for delay of payment of the assessment imposed in subsection (b) ~~of this Section~~ if the provider has not been paid due to problems related to State cash flow for services provided during

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the month in which the assessment is levied. 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 extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:
 - A) the facility 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), (f)(2) and (f)(3) ~~of this Section~~ would impose severe and irreparable harm to the clients served. Circumstances which may create such 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 facility's ability to provide further services to clients is severely impaired;
 - ii) cash flow problems encountered by a facility that are unrelated to Department technical system problems and which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.
 - B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:
 - i) 85% ~~percent~~ or more of their residents must be eligible for public assistance;
 - ii) a government-owned facility ~~that, which~~ meets the cash flow criterion under subsection (h)(1)(A)(ii) ~~of this Section~~;
 - iii) a provider who has filed for Chapter 11 bankruptcy, which meets cash flow criterion under subsection (h)(1)(A)(ii) ~~of this Section~~.

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- C) the facility must ensure that a delay of payment request, as defined under subsection (h)(3)(A) ~~of this Section~~, is received by the Department and the request must include a Cash Position Statement that is based upon current assets, current liabilities and other data for a date which 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 license fee or 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 license fee 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;
 - iii) cash or other assets has been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the license fee or assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.
- D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow license fee or 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 facility 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;

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- ii) specific dates on which payments must be received and the amount of payment ~~that~~which 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 facility as a result of institution of the delayed 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) ~~such~~ other terms and conditions that may be required by the Department.
- 2) A facility that does not meet the ~~above~~ criteria in subsection (h)(1) may request a delayed payment schedule, prior to the due date. The Department may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. 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, facilities 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 due date designated

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by the Department. Providers will be notified, in writing, of 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 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 license fee or 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 facility.
- B) The facility shall be notified by the Department, in writing prior to the license fee or 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 facility for all approved requests. The agreement must be signed by the administrator, owner 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 facility's request for institution of delayed payment provisions. In the event a facility'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~~, the penalties shall be permanently waived for the subject quarter or month as it pertains to assessment, unless the facility fails to meet all of the terms and conditions of the agreement.

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In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such 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 facility meets the criteria in subsections (h)(1)(A) and (B) ~~of 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 facility has requested and received approval for delayed payment arrangements, the facility 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 delay of payment agreement. The waiver of penalties described in subsection (h)(4) ~~of this Section~~ shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.
 - i) Administration and Enforcement Provisions
The Department shall administer and enforce [Section 305 ILCS 5/5B-7 of the Code](#), and collect the license fees, assessments, interest, and penalty fees imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under [the Retailers' Occupation Tax Act \(ROTA\)](#).
 - j) Nothing in [Section 305 ILCS 5/5B of the Code](#) shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before July 1, 1995.
 - k) Definitions
As used in this Section, unless the context requires otherwise:
 - 1) "Department" means the Illinois Department of Healthcare and Family

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Services.

- 2) "Fund" means the Long Term Care Provider Fund.
- 3) "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.
- 4) "Licensed nursing bed days" means, with respect to a nursing home provider, the sum for all nursing beds, with the exception of swing-beds, as described in subsection (k)(11) ~~of this Section~~, of the number of days during a calendar quarter on which each bed is covered by a license issued to that provider under the Nursing Home Care Act or the Hospital Licensing Act.
- 5) "Long term care facility" means a nursing facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act or the MR/DD Community Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code, and a part of a hospital in which skilled or intermediate long term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided; except that the term "long term care facility" does not include a facility operated by a State agency or operated solely as an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act.
- 6) "Long term care provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long term care facility or a hospital provider that provides skilled or intermediate long term care services within the meaning of Title XVII or XIX of the Social Security Act. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability

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company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

- 7) "Nursing home" means a skilled nursing or intermediate long term care facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided. However, the term "nursing home" does not include a facility operated solely as an intermediate care facility for the mentally retarded within the meaning on Title XIX of the Social Security Act.
- 8) "Nursing home provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long term care facility which charges its residents, a third party payor, Medicaid, of Medicare for skilled nursing or intermediate long term care services; or a hospital provider that provides skilled or intermediate long term care services within the meaning of Title XVIII or XIX of the Social Security Act.
- 9) "Occupied bed days" shall be computed separately for each long term care facility operated or maintained by a long term care provider, and means the sum, for all beds, of the number of days during the month on which each bed was occupied by a resident, other than a resident for whom Medicare Part A is primary payer. [For a resident whose care is covered by the Medicare-Medicaid Alignment Initiative demonstration, Medicare Part A is considered the primary payer to the extent Medicare would have been the primary payer in the absence of the demonstration.](#)
- 10) "Person" means, in addition to natural persons, 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.
- 11) "Swing-beds" means those beds for which a hospital provider has been

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granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.86 Supportive Living Facility Fund**a) Purpose and Contents**

- 1) The Supportive Living Facility Fund was created in the State Treasury on July 1, 2014 (see 305 ILCS 5/5G-35). 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 5G-10 and 35 of the Code.
- 3) The Fund shall consist of:
 - A) All monies collected or received by the Department under subsection (b);
 - B) All monies collected or received by the Department under subsection (j);
 - C) 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;
 - D) Any interest or penalty levied in conjunction with the administration of the Fund;
 - E) All monies transferred from another fund in the State Treasury; and
 - F) All other monies received for the Fund from any other source, including interest earned on monies in the Fund.

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b) Provider Assessment

Beginning on July 1, 2014, an annual assessment is imposed upon each supportive living facility in an amount equal to \$2.30 for each supportive living facility's care days. This assessment shall not be billed or passed on to any resident of a supportive living facility.

c) Payment of Assessment and Assessment Due

1) The assessment described in subsection (b) of this Section shall be due and payable monthly, on the last State business day of the month for care days reported for the preceding third month prior to the month in which the assessment is payable and due. A facility that has its payments from the State delayed, due to problems related to State cash flow, may request an extension on the due date for payment pursuant to subsection (c) and shall pay the assessment within 30 days after reimbursement by the Department.

A) The Department shall provide for an electronic submission process for each supportive living facility to report at a minimum the number of care days of the supportive living facility for the reporting period and other reasonable information the Department requires for the administration of its responsibilities. To the extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of supportive living facilities.

B) The Department shall prepare an assessment, based on the reported care days, and will bill the facility stating the amount due and payable each month and submit it to each supportive living facility via an electronic process. Each assessment payment shall be accompanied by a copy of the assessment bill sent to the supportive living facility by the Department.

C) The provider assessment imposed by this Section shall not be due and payable until after the Department notifies the supportive living facilities, in writing, that the payment

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methodologies to supportive living facilities required under Section 5-5.01a of the Public Aid Code have been approved and the waivers under 42 CFR 433.68, if necessary, have been granted by CMMS.

D) The provider assessment imposed by this Section shall cease to be imposed if the amount of matching federal funds under Title XIX of the Social Security Act is eliminated or significantly reduced on account of the assessment. Any remaining assessments shall be refunded to supportive living facilities in proportion to the amounts of the assessments paid by them.

3) All payments received by the Department shall be credited first to unpaid assessment payment amounts (rather than to penalty or interest), beginning with the most delinquent assessment payments.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) Every supportive living facility subject to the assessment described in subsection (b) shall report the number of care days of the supportive living facility for the reporting period on or before the last business day of the month following the reporting period. Each supportive living facility shall ensure that an accurate e-mail address is on file with the Department in order for the Department to prepare and send an electronic bill to the supportive living facility.

2) If a provider operates or maintains more than one supportive living facility, a separate report shall be filed for each facility. In the case of a provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice president, secretary or treasurer or by its properly authorized agent.

3) If the provider fails to file its monthly report on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the assessment imposed in subsection (b) a penalty fee equal to 25% of the assessment due.

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- 4) Every provider subject to a license fee or assessment under subsection (b) shall keep records and books that will permit the determination of care days on a calendar year basis. All such books and records shall be kept in the English language and shall, at all times during business hours, be subject to inspection by the Department or its duly authorized agents and employees.
 - 5) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with this subsection (d)(5), an amended monthly assessment report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.
 - 6) Reconsideration of Adjusted Assessment. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a provider, the provider may request a review or reconsideration of the adjusted assessment within 30 days after the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if those requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.
- e) Procedure for Partial Year Reporting/Operating Adjustments
- 1) Cessation of Business Prior to the Monthly Due Date. A provider who ceases to conduct, operate, or maintain a facility for which the provider is subject to the assessment imposed under subsection (b), and for which closure occurs prior to the due date for the assessment period, shall file a final report with the Department within 30 days after the closure date. The final report will reflect the number of days the facility was operational during the

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assessment period and the corresponding final assessment amount. Closure dates will be verified with the Department of Public Health and, if necessary, adjustments will be made to the final assessment due. (Example: Facility closes on January 17. On or before February 17, the facility must file a final report for the reporting month of January 1 through January 31. The report would reflect 17 days of operation (January 1 through January 17) during the month and must be accompanied by the final assessment payment for the facility.)

- 2) Commencing of Business During the Month in Which the Assessment is Being Paid. A provider who commences conducting, operating, or maintaining a facility for which the person is subject to the assessment imposed under subsection (b) shall file an initial report for the assessment period in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (c).
- 3) Change in Ownership and/or Operators. The full monthly assessment 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 assessment and any interest or penalties that may have accrued against the amount) rests on the provider currently operating or maintaining the nursing facility regardless of whether these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment/license fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment/license fee liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1).
- 4) Upon request, the Department will share with a potential buyer of a facility information on outstanding assessments and penalties owed by that facility.

f) Penalties

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- 1) Any provider that fails to pay the full amount of an assessment payment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to one percent of the amount of the assessment payment not paid on or before the due date, plus one percent of the portion thereof remaining unpaid on the last day of each monthly period thereafter, not to exceed 100% of the assessment amount not paid on or before the due date. Reasonable cause may include but is not limited to:
 - A) a provider who has not been delinquent on payment of an assessment payment due within the last three calendar years from the time the delinquency occurs;
 - B) a provider who can demonstrate to the Department's satisfaction that a payment was made prior to the due date;
or
 - C) that the provider is a new owner/operator and the late payment occurred in the assessment period 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 providers participating in the Medicaid Program. Payments may be withheld from the provider until the entire assessment, including any 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 provider fails to comply with an agreement, the Department reserves the right to recover any outstanding assessment, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with the 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) will continue to accrue during the recoupment process. Recoupment proceedings against the same provider two times in a fiscal year may be cause for termination from the program. Failure by the Department to initiate recoupment activities within 30 days shall not reduce the provider's liabilities

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nor shall it preclude the Department from taking action at a later date.

- 3) If the provider 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 license fee or assessment due date, the Department may initiate either administrative or judicial proceedings, or both, to enforce provisions of this Section. Administrative enforcement proceedings initiated under this subsection (f)(3) shall be governed by the Department's administrative rules. Judicial enforcement proceedings initiated under this subsection (f)(3) shall be governed by the rules of procedure applicable to the courts of this State.
- 4) 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 supportive living facility before the expiration of this limitation period.
- 5) Any unpaid assessment and/or penalties shall become a lien upon the assets of the supportive living facility upon which it was assessed. If any supportive living facility, 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 supportive living facility that is subject to the provisions of this Section, the seller or transferor shall pay the Department the amount of any assessment, penalty and interest (if any) due from it under this Section up to the date of the sale or transfer. If the seller or transferor fails to pay any assessment, penalty and interest (if any) due, the purchaser or transferee of the asset shall be liable for the amount of the assessment, penalty 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, penalty, and interest (if any) up to the amount of the

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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 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 this Section.

g) Delayed Payment – Groups of Facilities

The Department may establish delayed payment of assessment and/or waive the payment of interest and penalties for groups of facilities when:

- 1) the State delays payments to facilities 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 facilities will be unable to obtain a loan to pay the assessment.

h) Delayed Payment – Individual Facilities

In addition to the provisions of subsection (g), the Department may delay assessments for individual facilities 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 month following the month the assessment payment was to have been received by the Department as described in subsection (c). The Department may not deny a request for delay of payment of the assessment imposed in subsection (b) if the provider has not been paid due to problems related to State cash flow for services provided during the month in which the assessment is levied. 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 extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:
 - A) The facility has experienced an emergency that necessitates institution of delayed payment provisions. Emergency, in

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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), (f)(2) and (f)(3) would impose severe and irreparable harm to the clients served. Circumstances that may create these 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 facility's ability to provide further services to clients is severely impaired;
 - ii) cash flow problems encountered by a facility that are unrelated to Department technical system problems and that result in extensive financial problems for a facility, adversely impacting its ability to serve its clients.
- B) The facility serves a significant number of clients under the Medical Assistance Program. Significant, in this instance, means:
- i) 85% or more of the facility's residents are eligible for public assistance;
 - ii) The facility is a government-owned facility that meets the cash flow criterion of subsection (h)(1)(A)(ii);
 - iii) The facility is a provider who has filed for Chapter 11 bankruptcy, which meets the cash flow criterion of subsection (h)(1)(A)(ii).
- C) The facility must ensure that a delay of payment request, as defined under subsection (h)(3)(A), is received by the Department 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

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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 license fee or 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 license fee 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;
 - iii) cash or other assets have been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the license fee or assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.
- D) The facility, with the exception of government-owned facilities, must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institution such as a commercial bank. The denial must be 90 days old or less.
- E) The facility 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;

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- 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) that shall be due from the facility as a result of institution of the delayed 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) such other terms and conditions that may be required by the Department.
- 2) A facility that does not meet the criteria of subsection (h)(1) may request, prior to the due date, a delayed payment schedule. The Department may approve the request, notwithstanding the facility not meeting these criteria, upon a sufficient showing of financial difficulties and good cause by the facility. 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, facilities 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 Hospital and Provider Services. The request must be received by the

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due date designated by the Department. Providers will be notified, in writing, of 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 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), a denial of application to borrow the license fee or assessment as defined in subsection (h)(1)(D), and an explanation of the risk of irreparable harm to the clients; and
- iii) specification of the specific arrangements requested by the facility.

B) The facility 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 facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in the agreement.

- 4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility'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), the penalties shall be permanently waived for the subject month as it pertains to

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assessment, unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and 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). The interest may be waived by the Department if the facility's current ratio, as described in subsection (h)(1)(C), is 1.5 or less and the facility meets the criteria in subsections (h)(1)(A) and (B). Any waivers granted shall be expressly identified in the agreement.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until 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 delay of payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions
The Department shall administer and enforce Section 5G-5 of the Code and collect the assessments, interest, and penalty fees imposed under the law, using procedures employed in its administration of the Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act (ROTA).

j) Certification Fee
The Department shall collect an annual certification fee of \$100 per each operational or approved supportive living facility for the purposes of funding the administrative process of reviewing new supportive living facility applications and administrative oversight of the health care services delivered by supportive

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living facilities. The certification fee imposed by this subsection shall cease to be imposed if the amount of matching federal funds under Title XIX of the Social Security Act is eliminated or significantly reduced on account of the certification fee.

k) Definitions

As used in this Section, unless the context requires otherwise:

- 1) "Department" means the Illinois Department of Healthcare and Family Services.
- 2) "Fund" means the Supportive Living Facility Fund.
- 3) "Supportive Living Facility" means an enrolled supportive living site as described Section 5-5.01a of the Code that meets the participation requirements under 89 Ill. Adm. Code 146.215.
- 4) "Care Days" means, with respect to a supportive living facility, the sum for all apartment units, the number of days during the month in which each apartment unit was occupied by a resident.

(Source: Added at 38 Ill. Reg. _____, effective _____)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.420 Dental Services

Effective for dates of service on or after July 1, 2014, except as otherwise specified in this Section:

- a) Except as outlined in subsection (b), ~~payment~~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 services.~~
- b) Payment for oral health screening and fluoride varnish services shall be made to enrolled licensed dentists, and physicians or advance practice nurses (APNs) who are trained and approved to provide oral health screening and fluoride varnish services.

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- c) Payment for comprehensive orthodontic care shall be made only to a dentist licensed for provision of those services.
- db) Except~~Effective July 1, 2012, except~~ as specified in subsections ~~(e)(e)~~ and ~~(f)(d)~~, payment shall be made for allowable dental procedure codes specified in the Dental Office Reference Manual (DORM, July 1, 2014) available at the Department's website at <http://www2.illinois.gov/hfs/MedicalProvider/MedicaidReimbursement/Pages/Dental.aspx>, which are covered dental services as described in subsections (b)(1) and (b)(2) and as listed in Table D:
- 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);~~ and
 - 3) Performed by the dentist or under the direct supervision of the dentist, or for oral health screening and fluoride varnish services, performed by or under the direct supervision of an enrolled licensed dentist, physician or APN.
- ee) Payment shall not be made for experimental dental care and procedures performed only for cosmetic reasons.
- fd) Effective for dates of service ~~on or after~~ July 1, 2012 through June 30, 2014, 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 38 Ill. Reg. _____, effective _____)

Section 140.421 Limitations on Dental Services

Effective for dates of service on or after July 1, 2014:

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- a) The Department shall impose prior approval requirements to determine the medical necessity of particular dental services as specified by the Dental Office Reference Manual (DORM, July 1, 2014) available at the Department's website at <http://www2.illinois.gov/hfs/MedicalProvider/MedicaidReimbursement/Pages/Dental.aspx>. Prior approval is required for:
- 1) ~~Space maintainers;~~
 - 2) ~~Crowns;~~
 - 3) ~~Endodontic services with the exception of therapeutic pulpotomy;~~
 - 4) ~~Periodontal services;~~
 - 5) ~~Dentures, partial dentures and denture relines;~~
 - 6) ~~Maxillofacial prosthetics;~~
 - 7) ~~Bridgework;~~
 - 8) ~~Removal of impacted teeth;~~
 - 9) ~~Surgical removal of residual roots;~~
 - 10) ~~Surgical exposure to aid eruption;~~
 - 11) ~~Alveoloplasty;~~
 - 12) ~~Incision and drainage of abscess;~~
 - 13) ~~Frenulectomy;~~
 - 14) ~~Orthodontics. Medically necessary orthodontic treatment is approved for children. The Department's consultant shall make the initial decision whether or not to approve orthodontic treatment. Medically necessary orthodontic treatment is defined as:~~
 - A) ~~treatment necessary to correct a condition which scores 42 points or more on the Salzmann Index, or~~

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- ~~B) treatment necessary to correct a condition that constitutes a handicapping malocclusion. (A malocclusion is handicapping if there is an impairment of or a hazard to the ability to eat, chew, speak or breathe that is related to the malocclusion.);~~
- ~~15) Analgesia (nitrous oxide);~~
- ~~16) Therapeutic drug injection;~~
- ~~17) Other drugs and medicaments;~~
- ~~18) Unspecified miscellaneous adjunctive general services procedure or service;~~
- ~~19) Dental services not included in the Department's Schedule of Dental Procedures (see Table D of this Part).~~
- b) The dentist may request post-approval when a dental procedure requiring prior approval is provided on an emergency basis. Approval of the procedures shall be given if ~~the dental procedure is medically necessary, in the judgment of a consulting dentist of the Department or a consulting dental service, the procedure is necessary to prevent dental disease or to restore and maintain adequate dental function to assure good bodily health and the well-being of the patient.~~
- e) ~~Payment for complete and partial dentures is limited to one set every five years if necessary to replace lost, broken or unusable dentures; payment for a bridge is limited to once in five years. Bridgework will be reimbursed only if there has not been placement of a partial denture within the prior five years.~~
- d) ~~Root canals, apexification, and apicoectomy procedures are covered for children for anterior teeth, bicuspid, and permanent first molars. Root canals are covered for adults only for anterior teeth.~~
- e) ~~Panoramic x-rays are covered only once every three years.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.425 Podiatry Services

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- a) Payment for podiatry services shall be made only to licensed podiatrists.
- b) Effective July 1, 2012 through September 30, 2014, 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 Classification of Diseases. The allowable diagnosis code ranges will be reflectedspecified in the Handbook for Providers of Podiatric Services.
- c) Payment shall be made for the following:
- 1) Effective July 1, 2012 through September 30, 2014, payment shall be made for those podiatric services that are:
- A1) 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.
- B2) Essential for the diagnosis and treatment of conditions of the feet.
- C3) Listed in the Current Procedural Terminology (CPT) fourth edition published by the American Medical Association, for podiatric office visits, diagnostic radiology, pathology, or orthomechanical procedures included in the Department's schedule of podiatric services.
- D4) Performed by the podiatrist or under the direct supervision of the podiatrist.
- E5) Routine foot care services (trimming of nails, treatment of calluses, corns, and similar services) when a participant is under active treatment for diabetes mellitus.
- 2) Effective October 1, 2014, payment shall be made for those podiatric services that are:
- A) Essential for the diagnosis and treatment of conditions of the feet.

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- B) Listed in the CPT for podiatric office visits, diagnostic radiology, pathology, or orthomechanical procedures included in the Department's schedule of podiatric services.
- C) Performed by the podiatrist or under the direct supervision of the podiatrist.
- D) Routine foot care services (trimming of nails, treatment of calluses, corns, and similar services) when a participant is under active treatment for diabetes mellitus.

- d) 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)(1)(E)(5);
 - 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 38 Ill. Reg. _____, effective _____)

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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 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 ~~that~~ 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 the organizations (the panel is selected by the 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 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 ~~that~~ which the Department and the consulting organization shall consider in determining whether reimbursement for the drug shall require prior approval.
 - 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

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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 ~~10~~ten working days after receipt of the agenda, transmit ~~those 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 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 the consulting organization~~.
- 9) Effective July 1, 2012, the Department shall provide that the following types of drugs are available without prior approval:
 - A) Contraceptive drugs and products; and
 - B) Non-innovator products, listed in the State of Illinois Drug Product Selection Program's current Illinois Formulary, when the innovator

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product is available without prior approval.

- b) Prior approval shall be given for drugs requiring 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.
- c) Decisions on all requests for prior approval by telephone or other telecommunications device and, upon the Department's receipt of the 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.
- d) In accordance with subsection (d)(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 (d), 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

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- C) Anti-Rejection Drugs.
- 2) Brand name prescription drugs are exempt from the prior approval requirements of this subsection (d) 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 [this](#) subsection ~~(e)(4)~~, 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; ~~and~~
- 4) [Effective July 1, 2014, Antipsychotics.](#)
- f) [Effective July 1, 2014, the Department shall exempt from the prior approval process required under subsection \(e\) children with complex medical needs enrolled in a care coordination entity contracted with the Department to solely coordinate care for those children, if the Department determines that the entity has a comprehensive drug reconciliation program.](#)

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.457 Therapy Services

Effective July 1, 2012, physical, occupational and speech/language services are provided for

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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 [and, through September 30, 2014](#), with a maximum of 20 visits allowed per discipline per State fiscal year for adults age 21 and over. Payment may be made for [prior approved](#) 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 38 Ill. Reg. _____, effective _____)

Section 140.458 Prior Approval for Therapy Services

- a) Effective July 1, 2012 [through September 30, 2014](#), 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.
- [b\)](#) [Effective October 1, 2014, prior approval shall be required for all individuals, except for individuals eligible for services under Medicare and except when the individual is under age 21 and the date of service is prior to July 1, 2015.](#)
- [cb\)](#) Approval will be granted when, in the judgment 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.
- [de\)](#) The decision to approve or deny a request for prior approval will be made within

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21 days after the date the request and all necessary information is received.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

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.
- d) Therapy services: Effective July 1, 2012 [through September 30, 2014](#), 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. [For services provided on and after October 1, 2014, these](#) These services require prior approval by the Department [for participants age 21 and over. For services on or after July 1, 2015, these services shall require prior approval by the Department for participants under age 21.](#)

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.485 Healthy Kids Program

- a) Program Description
 - 1) The Healthy Kids Program is the Early and Periodic Screening, Diagnosis and Treatment Program mandated by the Social Security Act (see 42 [USC U.S.C.](#) 1396a(43), 1396d(4)(B) (Supp. 1987)). The goals of the program are to:
 - A) improve the health status of Medicaid-eligible children ages birth through 20 years through the provision of preventive medical care and early diagnosis and treatment of conditions threatening the

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- child's health; ~~and~~
- B) reduce the long term costs of medical care to eligible children; ~~and-~~
- C) effective for dates of service on or after July 1, 2014, comply with the evidence-based practices detailed in the American Academy of Pediatrics Bright Futures Guidelines.
- 2) The Department strives to achieve these goals by offering the following services at no cost to an eligible child, except as may be limited by a spend down requirement:
- A) periodic and interperiodic health, vision, hearing and dental screening services to meet the health care needs of children (see Section 140.488(a) through (d));
- B) immunizations against childhood diseases (see Section 140.488(e));
- C) diagnostic laboratory procedures as described in Section 140.488(f);
- D) further diagnosis or treatment necessary to correct or ameliorate defects and physical or mental illnesses or conditions which are discovered or determined to have increased in severity by a provider as the result of a periodic or interperiodic health, vision, hearing or dental screening;
- E) effective for dates of service on or after July 1, 2014, referral for dental care beginning at age ~~onetwo~~; and
- F) assistance in locating a provider, scheduling an appointment and in arranging transportation to and from the source of medical care.
- 3) The Department also strives to protect each eligible person's right to freedom of choice regarding participation and selection of a health care provider and the right to continuity of care.
- b) Eligibility. Services are available to those persons listed in Section 140.3, except

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that ~~those~~ persons must be under 21 years of age at the time of receiving ~~the~~ services.

- c) Provider Participation. Providers of Healthy Kids services must be duly licensed or certified according to applicable ~~federal~~ Federal or State law or rule and be enrolled in the Illinois Medical Assistance Program to provide one or more Healthy Kids Program services as authorized in Title XIX of the Social Security Act and the Illinois Medical Assistance Program State Plan (as set forth in ~~Sections~~ 140.11 ~~through~~ 140.835).
- d) Program Activities and Services
- 1) Informing Clients. The Department shall inform eligible persons in writing about the benefits of preventive health care, the services which are available, and procedures by ~~that~~ which eligible persons may request and receive assistance in identifying an enrolled provider, scheduling an appointment or arranging transportation to and from the source of medical care. Effective July 1, 1990, the Department shall also notify Medicaid-eligible pregnant women, postpartum women during the six months after termination of pregnancy, women up to one year postpartum who are breastfeeding their infants or children below the age of five years of their potential eligibility for receiving services through the Special Supplemental Food Program for Women, Infants and Children which is ~~administered~~ administered by the Illinois Department of Public Health (IDPH). The informing of eligible persons shall be done as described in the ~~timeliness standards~~ Timeliness Standards contained in Section 140.487.
- 2) Periodic Medical Screenings. The Department will pay for a series of periodic medical screenings scheduled from a person's birth through age 20. The ~~periodicity schedule~~ Periodicity Schedule of screenings is contained in Section 140.488. The Department will pay for additional health screenings when necessary for:
- A) enrollment in school; ~~or~~
- B) enrollment in a licensed day care program, including Headstart; ~~or~~
- C) placement in a licensed child welfare facility, including a foster

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- home, group home or child care institution; ~~or~~
- D) attendance at a camping program; ~~or~~
- E) participation in an organized athletic program; ~~or~~
- F) enrollment in an early childhood education program recognized by the Illinois State Board of Education; ~~or~~
- G) participation in a Women, Infant and Children (WIC) program; or
- H) is requested by a child's parent, guardian or custodian, or is determined to be necessary by social services, developmental, health, or educational personnel.
- 3) Dental Screenings
Effective for dates of service on or after July 1, 2014:
- A) A dental screening shall be included as part of the well child visit at the appropriate intervals specified in the Dental Office Reference Manual (DORM) (July 1, 2014), available at the Department's website at <http://www2.illinois.gov/hfs/MedicalProvider/MedicaidReimbursement/Pages/Dental.aspx>. Dental screening is defined as an examination of a child's oral cavity, including the status of the teeth and gums. ~~Dental services shall include services for relief of pain and infections, restoration of teeth, and maintenance of dental health, including instruction in self-care oral hygiene procedures.~~
- B) A physician shall refer children to a dentist for routine and periodic preventive dental care within six months after the eruption of the first tooth or by age one. ~~Eligible persons shall be referred for dental screenings beginning at age two if the person is not in the continuing care of an enrolled dental provider, except that a child younger than age two years may be referred for dental services when any health screening indicates the need for dental services.~~
- C) The periodicity schedule for dental screening services is contained in Section 140.488. The Department will pay for one dental

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screening per age period unless a second screening is medically necessary.

- 4) Vision Screening
 - A) The Department will pay for vision screening services, and diagnosis and treatment for defects in vision, including glasses.
 - B) The periodicity schedule for vision screenings is contained in Section 140.488. The Department will pay for one vision screening per age period, except when a second screening is determined to be medically necessary.
- 5) Hearing Screening. The Department will pay for hearing screenings and diagnosis and treatment for defects in hearing, including hearing aids. The periodicity schedule for hearing screenings is contained in Section 140.488. The Department will pay for one hearing screening per age period, except when a second screening is determined to be medically necessary.
- 6) Immunizations. The Department will pay for the immunization of eligible children against childhood diseases. The list of covered immunizations is contained in Section 140.488(b).
- 7) Diagnostic Procedures
 - A) Lead Screening
 - i) The Department requires that lead screening shall be performed in compliance with the "Lead Poisoning Prevention Act [\[410 ILCS 45\]](#), ~~Public Act 87-175~~, as amended, effective January 1, 1992. Children between the ages of six months to six years should be screened for lead poisoning at priority intervals. Screenings and medical follow up shall be performed in accordance with the "Guidelines for the Detection and Management of Lead Poisoning for Physicians and Health Care Providers", published by the Illinois Department of Public Health. These guidelines recommend that those children at highest

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risk be screened on a regular basis. High risk environmental situations include housing built before 1978, housing ~~that~~^{which} is being renovated or remodeled, or ~~that~~^{which} is in deteriorating condition. Children six years and older shall also be screened, ~~when~~^{where} medically indicated or appropriate.

- ii) The Department will pay for lead screening as indicated in subsection (d)(7)(A)(i) ~~above~~ or as required for admission by a day care center, day care home, preschool, nursery school, kindergarten, or other child care facility or educational facility licensed by the State.
 - iii) The Department will pay for epidemiological study of the child's living environment when the child has been diagnosed as having an elevated blood lead level for the purpose of identifying the source of lead exposure.
- B) The Department will pay for the administration of all other medically necessary diagnostic procedures performed during or as the result of medical screenings.
- 8) Treatment. The Department shall pay for necessary medical care (see Section 140.2), diagnostic services, treatment or other measures medically necessary (e.g., medical equipment and supplies) to correct or ameliorate defects, and physical and mental illnesses and conditions which are discovered or determined to have increased in severity by medical, vision, hearing or dental screening services.
- 9) Assistance Services. The Department shall, upon request, provide assistance to eligible children and their parent, guardian or custodian to locate a provider, schedule an appointment or arrange transportation to and from the source of medical care.
- 10) Timeliness Standards. The ~~timeliness standards~~^{Timeliness Standards} in Section 140.487 will govern the completion of required activities and services.
- e) Reimbursement to Providers

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- 1) Fee-for-service. Provider's enrolled in the Maternal and Child Health Program, as described in Subpart G, will receive enhanced rates for certain services, as described in Section 140.930(a)(1). Payment will be made at the provider's usual and customary charges or the established Department ~~rates~~[rate\(s\)](#) (see Section 140.400), whichever is less, for providers not enrolled in the Maternal and Child Health Program. Reimbursement for the administration of immunizations to an eligible person will be made at rates established by the Department. The provider will receive replacement vaccines as explained in subsection (e)(3)~~-below~~.
- 2) Claims. Claims for reimbursement shall be submitted on the form and in a manner specified by the Department.
- 3) Vaccine Replacement Program. When a provider administers an immunization to an eligible child, the vaccines are replaced to the provider through the Vaccine Replacement Program which is administered jointly by the Department and the IDPH. Providers must be annually certified for participation in the Vaccine Replacement Program by IDPH before receiving replacement vaccines. Information on the Vaccine Replacement Program and certification procedures (set forth at 42 CFR 51b), may be obtained by contacting:

Immunization Vaccine Replacement Program
Illinois Department of Public Health
525 West Jefferson Street
Springfield, Illinois 62761
- f) Limitations on Services. Services under the Healthy Kids Program shall only be available to persons in the age groups from birth through age 20. Coverage of and payments for services shall be consistent with the requirements of ~~section~~[Section](#) 1905 of the Social Security Act (42 ~~U.S.C.~~ 1396d) as it relates to the Early and Periodic Screening, Diagnosis and Treatment Program.
- g) Record Requirements. The provider shall comply with record requirements as set forth in Section 140.28.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

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Section 140.488 Periodicity Schedules, Immunizations and Diagnostic Laboratory Procedures

- a) Health Screening Periodicity Schedule. Eligible clients may receive one periodic health screening during each of the following time periods, except a second screening may be given as explained in Section 140.485(d)(2):
- 1) ~~birth~~^{Birth} to two weeks;
 - 2) two weeks to one month;
 - 3) one to two months;
 - 4) two to four months;
 - 5) four to six months;
 - 6) six to nine months;
 - 7) nine to 12 months;
 - 8) 12 to 15 months;
 - 9) 15 to 18 months;
 - 10) 18 to 24 months;
 - 11) two to three years;
 - 12) three to four years;
 - 13) four to five years;
 - 14) five to six years;
 - 15) six to eight years;
 - 16) eight to ~~10~~^{ten} years;

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- 17) ~~10~~ten to 12 years;
 - 18) 12 to 14 years;
 - 19) 14 to 16 years;
 - 20) 16 to 18 years; and
 - 21) 18 to 21 years.
- b) Vision Screening Periodicity Schedule
- 1) Vision screening using age appropriate methods shall be part of all periodic or interperiodic health screenings.
 - 2) Beginning at age three through 20 years, the Department will pay for one vision screening performed by a qualified provider per year for an eligible child. However, the Department will pay for other such screenings when medically necessary, regardless of a child's age or medical history.
- c) Hearing Screening Periodicity Schedule
- 1) Hearing screening using age appropriate methods shall be part of all periodic or interperiodic health screenings.
 - 2) Beginning at age one year for children at high risk for hearing problems and age three years for all other children, the Department will pay for one hearing screening performed by a qualified provider per year for an eligible child. However, the Department will pay for other such screenings when medically necessary, regardless of a child's age or medical history.
- d) Dental Screenings Periodicity Schedule
- 1) [Effective for dates of service on or after July 1, 2014, the dental periodicity schedule is located in the Dental Office Reference Manual \(DORM, July 1, 2014\) available at the Department's website at http://www2.illinois.gov/hfs/MedicalProvider/MedicaidReimbursement/Pages/Dental.aspx](http://www2.illinois.gov/hfs/MedicalProvider/MedicaidReimbursement/Pages/Dental.aspx) ~~Examination of a child's oral cavity, including the status~~

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~~of the teeth and gums, shall be part of each periodic or interperiodic health screening.~~

- 2) ~~Effective for dates of service on or after July 1, 2014, beginning~~Beginning at age ~~onetwo~~ through 20 years, the Department will pay for one clinical oral examination ~~per year~~ and ~~one~~ oral prophylaxis not more frequently than once every six months performed by an enrolled dentist. However, the Department will pay for ~~additional~~~~other such~~ services when medically necessary, regardless of a child's age or medical history.

e) Immunizations. The following immunizations are available to eligible clients:

- 1) Diphtheria-Tetanus-Pertussis (DPT) 1;
- 2) DPT 2;
- 3) DPT 3;
- 4) DPT Booster 1;
- 5) DPT Booster 2;
- 6) Oral Polio Vaccine (OPV) 1;
- 7) OPV 2
- 8) OPV 3;
- 9) OPV Booster 1;
- 10) OPV Booster 2;
- 11) Diphtheria-Tetanus (Td) 1;
- 12) Td 2;
- 13) Td 3;
- 14) Td Booster 1;

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- 15) Td Booster 2;
 - 16) Measles;
 - 17) Rubella;
 - 18) Mumps;
 - 19) Measles/Mumps/Rubella (M/M/R);
 - 20) Measles/Rubella; and
 - 21) Haemophilus b Conjugated.
- f) Diagnostic Laboratory Procedures. The Department will pay for covered diagnostic laboratory procedures as medically necessary including but not limited to:
- 1) Urinalysis, routine (ph specific gravity protein tests for reducing substances such as glucose), with microscopy;
 - 2) Urinalysis routine without microscopy;
 - 3) Chemical, qualitative, any number of constituents;
 - 4) Cholesterol, serum; total;
 - 5) Cholesterol, serum; total and ester;
 - 6) Lead Screening, Blood Lead;
 - 7) Gonadotropin, chorionic quantitative pregnancy test;
 - 8) Gonadotropin, chorionic qualitative pregnancy test;
 - 9) Hematocrit;
 - 10) Hemoglobin Colorimetric;

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- 11) Sickle RBC, reduction slide method;
- 12) Hemoglobin Electrophoresis;
- 13) Sickle Hemoglobin;
- 14) Tuberculosis intradermal;
- 15) TB Tine Test;
- 16) Syphilis Test, qualitative;
- 17) GC Culture Test, bacterial screening only;
- 18) Culture presumptive, pathogenic organisms screening only;
- 19) Culture, multiple organisms;
- 20) Urine culture colony count;
- 21) Urine bacteria count, commercial kit;
- 22) Urine bacteria culture, identification, in addition to colony count and commercial kit;
- 23) Chlamydia Culture;
- 24) Pap Smear, Cytopathology;
- 25) Epidemiological study of a child's living environment when a child has been diagnosed as having an abnormally high blood lead level;
- 26) Denver Developmental Screening Test; and
- 27) Other developmental tests ~~that~~[which](#) may be approved by the Department.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

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Section 140. TABLE D Schedule of Dental Procedures (Repealed)

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) ~~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
- e) 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

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- A) ~~Resin-based composite—1 surface, anterior~~
- 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~~

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- 4) ~~Osseous surgery—per quadrant, ages 0-20 years~~
- 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~~

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- B) ~~Mandibular partial denture—resin base, ages 2-20 years~~
 - 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~~

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- ~~H) Reline mandibular partial denture, laboratory~~
- 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~~

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- S) ~~Mandibular resection, prosthesis with guide flange~~
- 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~~
- I) ~~Commissure splint~~
- J) ~~Surgical splint~~
- KK) ~~Unspecified maxillofacial prosthesis~~

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- g) ~~Fixed Prosthetic Services~~
 - 1) ~~Bridge Pontics~~
 - 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) ~~Surgical Extractions~~
 - A) ~~Surgical removal of erupted tooth~~

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- B) ~~Removal of impacted tooth—soft tissues~~
- C) ~~Removal of impacted tooth—partially bony~~
- 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) ~~Other Surgical Procedures~~
~~Surgical exposure to aid eruption, ages 2-20 years~~
- 6) ~~Alveoloplasty~~
 - A) ~~Alveoloplasty in conjunction with extractions, ages 2-20 years~~
 - B) ~~Alveoloplasty not in conjunction with extractions, ages 2-20 years~~
- 7) ~~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) ~~Treatment of Fractures—Simple~~
 - A) ~~Maxilla—open reduction, teeth immobilized~~
 - B) ~~Maxilla—closed reduction, teeth immobilized~~
 - C) ~~Mandible—open reduction, teeth immobilized~~

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- ~~D) Mandible—closed reduction, teeth immobilized~~
- 9) Treatment of Fractures—Compound
 - ~~A) Maxilla—open reduction~~
 - ~~B) Maxilla—closed reduction~~
 - ~~C) Mandible—open reduction~~
 - ~~D) Mandible—closed reduction~~
- 10) Reduction of Dislocation
 - ~~A) Open reduction of dislocation~~
 - ~~B) Closed reduction of dislocation~~
- 11) 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~~

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- A) ~~Palliative (emergency) treatment of dental pain—minor procedures~~
- B) ~~General anesthesia~~
- 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) ~~Professional Consultation~~
~~Consultation (narrative; diagnostic services provided by dentist other than practitioner providing treatment)~~
- 4) ~~Drugs~~
 - A) ~~Therapeutic drug injection~~
 - B) ~~Other drugs and medicaments~~
- 5) ~~Miscellaneous Services~~
 - A) ~~Unspecified procedures 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: Repealed at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Mental Health Services In Nursing Facilities
- 2) Code Citation: 89 Ill. Adm. Code 145
- 3)

<u>Section Number:</u>	<u>Proposed Action:</u>
145.10	Repeal
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5]
- 5) Complete Description of the Subject and Issues Involved: PA 98-14 authorizes the repeal of Section 145.10.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule 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>Section Number:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
145.30	Amendment	38 Ill. Reg. 14076; July 11, 2014
- 11) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.
- 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., 3rd 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: Medicaid funded providers
 - 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: This rulemaking was not anticipated by the Department when the 2 most recent regulatory agendas were published.

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

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NOTICE OF PROPOSED AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMSPART 145
MENTAL HEALTH SERVICES IN NURSING FACILITIESSUBPART A: DEMONSTRATION PROJECT FOR
MENTAL HEALTH SERVICES IN NURSING FACILITIES

Section

145.10 General Provisions (Repealed)SUBPART B: INSTITUTION FOR MENTAL DISEASES PROVISIONS
FOR NURSING FACILITIES

Section

145.20 General Provisions
145.30 Definitions
145.40 Initial IMD Review, Determination and Classification of Facilities
145.50 Subsequent IMD Reviews, Determinations and Classifications
145.60 Effect of Becoming a Class II IMD and Redetermination Reviews
145.70 Watch List of Nursing Facilities at Risk of Becoming IMDs
145.80 Reimbursement Rate for IMD Nursing Facility Classifications
145.90 Reviews

AUTHORITY: Sections 5-5.5 and 12-13 of the Illinois Public Aid Code [305 ILCS 5/5-5.5 and 12-13]

SOURCE: Adopted at 26 Ill. Reg. 3081, effective February 15, 2002; emergency amendment at 29 Ill. Reg. 10259, effective July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 18906, effective November 4, 2005; amended at 38 Ill. Reg. _____, effective _____.

SUBPART A: DEMONSTRATION PROJECT FOR
MENTAL HEALTH SERVICES IN NURSING FACILITIES**Section 145.10 General Provisions (Repealed)**

- a) ~~This Section is promulgated to establish a demonstration project for nursing facilities that primarily serve persons with severe mental illness. The Department~~

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~~intends to evaluate the results of the demonstration project at the end of three years. General applicability of the provisions of this Subpart will depend upon the findings of the evaluation. It is the Department's intent to make the project a standard category of service after reviewing the results of the evaluation. Section 1905(a)(16) and Section 1905(a)(27)(b) of the Social Security Act provide that federal financial participation (FFP) is not available for medical assistance under Title XIX for services provided to any individual who is under 65 years of age and who is a resident in an institution for mental diseases (IMD) unless the payment is for inpatient psychiatric services for individuals under 21 years of age. In some Illinois nursing facilities, a very high proportion of residents are not elderly and have a severe mental illness. The purpose of the demonstration project is to allow nursing facilities to specialize in the treatment of persons with severe mental illness and focus their resources on providing psychiatric rehabilitation services rather than on meeting requirements designed primarily for elderly and medically impaired residents. The demonstration project will focus upon evaluating standards and payment methods specific to the needs of facilities specializing in serving persons with mental illness. The facilities in the demonstration project will serve as sites for examining service models appropriate for the mentally ill population in a long term care setting. They will also serve as sites for comparing costs for the numbers and credentials of staff appropriate for the physically, medically ill population. The cost information evaluated from the demonstration project will be used by the Department to develop a payment rule for services provided by a nursing facility to residents who have a serious mental illness as required by 305 ILCS 5/5-5.5(d). The demonstration project shall be in effect until June 30, 2007. The Department shall evaluate the demonstration project and report to the Illinois General Assembly regarding its findings and recommendations by December 31, 2004.~~

- b) ~~For the purposes of this Part, "severe mental illness" is defined as the presence of a major disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1400 K Street NW, Washington, DC 20005 (Fourth Printing, 1998, no later amendments or editions included)), excluding alcohol and substance abuse, Alzheimer's disease, and other forms of dementia based upon organic or physical disorders. A severe mental illness is determined by all of the following three areas:~~

1) ~~Diagnoses that constitute a severe mental illness are:~~

A) ~~Schizophrenia,~~

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- B) ~~Delusional disorder,~~
 - C) ~~Schizo-affective disorder,~~
 - D) ~~Psychotic disorder not otherwise specified,~~
 - E) ~~Bipolar disorder I—mixed, manic, and depressed,~~
 - F) ~~Bipolar disorder II,~~
 - G) ~~Cyclothymic disorder,~~
 - H) ~~Bipolar disorder not otherwise specified,~~
 - I) ~~Major Depression, recurrent,~~
 - J) ~~Psychotic disorder, not otherwise specified.~~
- 2) ~~In addition, the individual must be 18 years of age or older and be substantially functionally limited by mental illness in at least two of the following areas:~~
- A) ~~Self-maintenance,~~
 - B) ~~Social functioning,~~
 - C) ~~Community living activities,~~
 - D) ~~Work related skills.~~
- 3) ~~Finally, the disability must be of an extended duration, expected to be present for at least a year, that results in a substantial limitation in major life activities. These individuals will typically also have one of the following characteristics:~~
- A) ~~Have experienced two or more psychiatric hospitalizations;~~
 - B) ~~Receive Social Security Income (SSI) or Social Security Disability Income (SSDI) due to mental illness or have been deemed eligible for it.~~

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- e) ~~In order to be eligible to enter the demonstration project, a nursing facility must meet each of the following criteria:~~
- 1) ~~Ninety percent or more of the residents have a diagnosis of severe mental illness;~~
 - 2) ~~No more than 15 percent of the residents are 65 years of age or older;~~
 - 3) ~~None of the residents has a primary diagnosis of moderate, severe, or profound mental retardation;~~
 - 4) ~~None of the residents requires medical or nursing care at a level higher than the intermediate nursing care light level of care as defined in 77 Ill. Adm. Code 300.1230(n); and~~
 - 5) ~~The facility must be in good standing with the Departments of Healthcare and Family Services and Public Health.~~
- d) ~~Nursing facilities that meet the criteria set forth in subsection (c) of this Section may apply to the Department to be considered for participation in the demonstration project. In selecting facilities for the demonstration project, the Department shall consider other factors beyond the criteria in subsection (c) of this Section such as, but not limited to, the facility's history of compliance with all applicable State and federal standards and the effect of lost federal funds associated with withdrawal from certification. The Department will enter into provider agreements with those facilities selected for the demonstration project. No more than 12 facilities shall be admitted to the demonstration project.~~
- e) ~~Nursing facilities participating in the demonstration project must comply with the standards set forth in 77 Ill. Adm. Code 300.6000 through 300.6095. Based on a finding of noncompliance by the Department of Public Health on the part of a nursing facility participating in the demonstration project with any requirement set forth in 77 Ill. Adm. Code 300.6000 through 300.6095, the Department may impose sanctions as set forth in 89 Ill. Adm. Code 147.301 after notice to the facility.~~
- f) ~~Notwithstanding any other provisions contained in the Administrative Code requiring certification of nursing facilities, nursing facilities participating in the demonstration project are not required to be certified for Title XIX participation~~

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~~in order to enroll for participation in the Medical Assistance Program or to receive payment for services.~~

- g) ~~The Department shall not pay for any new admissions to the nursing facilities participating in the demonstration project of residents who:~~
- ~~1) Are age 60 years or older;~~
 - ~~2) Do not have a severe mental illness as determined by the State's mental health pre-admission screening program; or~~
 - ~~3) Require medical or nursing care at a level higher than the intermediate nursing care light level of care as defined in 77 Ill. Adm. Code 300.1230(n).~~
- h) ~~The Departments of Healthcare and Family Services and Public Health, and the Department of Human Services Division of Mental Health, shall have the right of entry and inspection of any nursing facilities participating in the demonstration project to determine success and utility of the demonstration project.~~
- i) ~~The Department shall provide technical assistance to nursing facilities participating in the demonstration project to assist them in meeting the standards set forth in 77 Ill. Adm. Code 300.6000 through 300.6095.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

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- 1) Heading of the Part: Specialized Health Care Delivery Systems
- 2) Code Citation: 89 Ill. Adm. Code 146
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
146.225	Amendment
146.650	Amendment
146.900	New Section
146.910	New Section
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Complete description of the subject and issues involved: Pursuant to PA 98-651, this rulemaking de-links the rates for supportive living facilities from nursing facility rates and for facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013, makes reimbursement changes, and makes certain governance changes.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule currently in effect? Yes
- 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>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
146.100	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.105	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.110	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.115	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.125	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.130	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.840	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.550	Amendment	38 Ill. Reg. 6499; March 21, 2014

- 11) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.

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- 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., 3rd Floor
Springfield IL 62763-0002

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: Medicaid funded providers
 - 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: This rulemaking was not anticipated by the Department when the most recent regulatory agendas were published.

The full text of the Proposed Amendments are identical to the Emergency Rule that begins on page 15713.

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- 1) Heading of the Part: Reimbursement for Nursing Costs for Geriatric Facilities
- 2) Code Citation: 89 Ill. Adm. Code 147
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
147.310	Amendment
147.335	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5] and PA 96-1530
- 5) Complete description of the subjects and issues involved: Pursuant to PA 98-651, makes certain rates changes for nursing facilities.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule currently in effect? Yes
- 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 Objective: This rulemaking does not affect units of local government.
- 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 East, 3rd Floor
Springfield IL 62763-0002

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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].

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid-certified nursing facilities
 - 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 2014

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

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TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER d: MEDICAL PROGRAMS

PART 147

REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

Section

- 147.5 Minimum Data Set-Mental Health (MDS-MH) Based Reimbursement System (Repealed)
- 147.15 Comprehensive Resident Assessment (Repealed)
- 147.25 Functional Needs and Restorative Care (Repealed)
- 147.50 Service Needs (Repealed)
- 147.75 Definitions (Repealed)
- 147.100 Reconsiderations (Repealed)
- 147.105 Midnight Census Report
- 147.125 Nursing Facility Resident Assessment Instrument (Repealed)
- 147.150 Minimum Data Set (MDS) Based Reimbursement System (Repealed)
- 147.175 Minimum Data Set (MDS) Integrity (Repealed)
- 147.200 Minimum Data Set (MDS) On-Site Review Documentation (Repealed)
- 147.205 Reimbursement for Ventilator Dependent Residents (Repealed)
- 147.250 Costs Associated with the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) (Repealed)
- 147.300 Payment to Nursing Facilities Serving Persons with Mental Illness
- 147.301 Sanctions for Noncompliance
- 147.305 Psychiatric Rehabilitation Service Requirements for Individuals With Mental Illness in Residential Facilities (Repealed)
- 147.310 Implementation of a Case Mix System
- 147.315 Nursing Facility Resident Assessment Instrument
- 147.320 Definitions
- 147.325 Resident Reimbursement Classifications and Requirements
- 147.330 Resource Utilization Groups (RUGs) Case Mix Requirements
- 147.335 Enhanced Care Rates
- 147.340 Minimum Date Set On-Site Reviews
- 147.345 Quality Incentives
- 147.346 Appeals of Nursing Rate Determination
- 147.350 Reimbursement for Additional Program Costs Associated with Providing Specialized Services for Individuals with Developmental Disabilities in Nursing Facilities

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- 147.355 Reimbursement for Residents with Exceptional Needs (Repealed)
- 147.TABLE A Staff Time (in Minutes) and Allocation by Need Level (Repealed)
147.TABLE B MDS-MH Staff Time (in Minutes and Allocation by Need Level) (Repealed)
147.TABLE C Comprehensive Resident Assessment (Repealed)
147.TABLE D Functional Needs and Restorative Care (Repealed)
147.TABLE E Service (Repealed)
147.TABLE F Social Services (Repealed)
147.TABLE G Therapy Services (Repealed)
147.TABLE H Determinations (Repealed)
147.TABLE I Activities (Repealed)
147.TABLE J Signatures (Repealed)
147.TABLE K Rehabilitation Services (Repealed)
147.TABLE L Personal Information (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, VI and 12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 140.900 thru 140.912 and 140.Table H and 140.Table I at 12 Ill. Reg. 6956; amended at 13 Ill. Reg. 559, effective January 1, 1989; amended at 13 Ill. Reg. 7043, effective April 24, 1989; emergency amendment at 13 Ill. Reg. 10999, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 16796, effective October 13, 1989; amended at 14 Ill. Reg. 210, effective December 21, 1989; emergency amendment at 14 Ill. Reg. 6915, effective April 19, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 9523, effective June 4, 1990, for a maximum of 150 days; emergency expired November 1, 1990; emergency amendment at 14 Ill. Reg. 14203, effective August 16, 1990, for a maximum of 150 days; emergency expired January 13, 1991; emergency amendment at 14 Ill. Reg. 15578, effective September 11, 1990, for a maximum of 150 days; emergency expired February 8, 1991; amended at 14 Ill. Reg. 16669, effective September 27, 1990; amended at 15 Ill. Reg. 2715, effective January 30, 1991; amended at 15 Ill. Reg. 3058, effective February 5, 1991; amended at 15 Ill. Reg. 6238, effective April 18, 1991; amended at 15 Ill. Reg. 7162, effective April 30, 1991; amended at 15 Ill. Reg. 9001, effective June 17, 1991; amended at 15 Ill. Reg. 13390, effective August 28, 1991; emergency amendment at 15 Ill. Reg. 16435, effective October 22, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 4035, effective March 4, 1992; amended at 16 Ill. Reg. 6479, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 13361, effective August 14, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 14233, effective August 31, 1992; amended at 16 Ill. Reg. 17332, effective November 6, 1992; amended at 17 Ill. Reg. 1128, effective January 12, 1993; amended at 17 Ill. Reg. 8486, effective June 1, 1993; amended at 17

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Ill. Reg. 13498, effective August 6, 1993; emergency amendment at 17 Ill. Reg. 15189, effective September 2, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 2405, effective January 25, 1994; amended at 18 Ill. Reg. 4271, effective March 4, 1994; amended at 19 Ill. Reg. 7944, effective June 5, 1995; amended at 20 Ill. Reg. 6953, effective May 6, 1996; amended at 21 Ill. Reg. 12203, effective August 22, 1997; amended at 26 Ill. Reg. 3093, effective February 15, 2002; emergency amendment at 27 Ill. Reg. 10863, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18680, effective November 26, 2003; expedited correction at 28 Ill. Reg. 4992, effective November 26, 2003; emergency amendment at 29 Ill. Reg. 10266, effective July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 18913, effective November 4, 2005; amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. 7409, effective September 11, 2006; amended at 31 Ill. Reg. 8654, effective June 11, 2007; emergency amendment at 32 Ill. Reg. 415, effective January 1, 2008, for a maximum of 150 days; emergency amendment suspended at 32 Ill. Reg. 3114, effective February 13, 2008; emergency suspension withdrawn in part at 32 Ill. Reg. 4399, effective February 26, 2008 and 32 Ill. Reg. 4402, effective March 11, 2008 and 32 Ill. Reg. 9765, effective June 17, 2008; amended at 32 Ill. Reg. 8614, effective May 29, 2008; amended at 33 Ill. Reg. 9337, effective July 1, 2009; emergency amendment at 33 Ill. Reg. 14350, effective October 1, 2009, for a maximum of 150 days; emergency amendment modified in response to the objection of the Joint Committee on Administrative Rules at 34 Ill. Reg. 1421, effective January 5, 2010, for the remainder of the 150 days; emergency expired February 27, 2010; amended at 34 Ill. Reg. 3786, effective March 14, 2010; amended at 35 Ill. Reg. 19514, effective December 1, 2011; amended at 36 Ill. Reg. 7077, effective April 27, 2012; emergency amendment at 38 Ill. Reg. 1205, effective January 1, 2014, for a maximum of 150 days; Sections 147.335(a)(7)(B) and 147.355(b) of the emergency amendment suspended by the Joint Committee on Administrative Rules at 38 Ill. Reg. 3385, effective January 14, 2014; suspension withdrawn at 38 Ill. Reg. 5898, effective March 7, 2014; emergency amendment modified in response to JCAR Objection at 38 Ill. Reg. 6707, effective March 7, 2014, for the remainder of the 150 days; amended at 38 Ill. Reg. 12173, effective May 30, 2014; amended at 38 Ill. Reg. _____, effective _____.

Section 147.310 Implementation of a Case Mix System

- a) P.A. 98-0104 requires the Department to implement, effective January 1, 2014, an evidence-based payment methodology for the reimbursement of nursing services. The methodology shall take into consideration the needs of individual residents, as assessed and reported by the most current version of the nursing facility Minimum Data Set (MDS), adopted and in use by the federal government.
- b) This Section establishes the method and criteria used to determine the resident reimbursement classification based upon the assessments of residents in nursing

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facilities. Resident reimbursement classification shall be established utilizing the 48-group, Resource Utilization Groups IV (RUG-IV) classification scheme and weights as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ([federal CMS](#)). An Illinois specific default group is established in subsection (f)(3) ~~of this Section~~ and identified as AA1 with an assigned weight equal to the weight assigned to group PA1.

- c) The pool of funds available for distribution by case mix shall be determined using the formula contained below. Base rate spending pool shall be:
 - 1) The base year resident days, which are calculated by multiplying the number of Medicaid residents in each nursing facility based on MDS comprehensive assessments for Medicaid residents on March 31, 2012, multiplied by 365 days.
 - 2) Each facility's nursing component per diem in effect on July 1, 2012 shall be multiplied by the number determined in subsection (c)(1) ~~of this Section~~.
 - 3) Thirteen million is added to the result of subsection (c)(2) of this Section, to adjust for the exclusion of nursing facilities defined as Class I IMDs.
- d) For each nursing facility with Medicaid residents as indicated by the MDS data defined in subsection (c)(1) of this Section, weighted days adjusted for case mix and regional wage adjustment shall be calculated. For each nursing facility this calculation is the product of:
 - 1) Base year resident days as calculated in subsection (c)(1) ~~of this Section~~.
 - 2) The nursing facility's regional wage adjustor based on the Health Service Areas (HSA) groupings and adjustors in effect on April 30, 2012.
 - 3) Facility weighted case mix which is the number of Medicaid residents as indicated by the MDS data defined in subsection (c)(1) ~~of this Section~~ multiplied by the associated case weight for the RUG-IV 48-group model using standard RUG-IV procedures for index maximization.

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- 4) The sum of the products calculated for each nursing facility in subsections (d)(1) through (d)(3) ~~of this Section~~ shall be the base year case mix, rate adjusted weighted days.
- e) The statewide RUG-IV nursing base per diem rate effective on:
- 1) January 1, 2014, shall be the quotient of subsection (c) ~~of this Section~~ divided by the sum calculated under subsection (d)(4) ~~of this Section~~ and is \$83.49.
- 2) July 1, 2014 shall be the rate calculated in subsection (e)(1) increased by \$1.76.
- f) For services provided on or after:
- 1) January 1, 2014, the Department shall compute and pay a facility-specific nursing component of the per diem rate as the arithmetic mean of the resident-specific nursing components, as determined in subsection (d) ~~of this Section~~, assigned to Medicaid-enrolled residents on record, as of 30 days prior to the beginning of the rate period, in the Department's Medicaid Management Information System (MMIS), or any successor system, as present in the facility on the last day of the second quarter preceding the rate period. The RUG-IV nursing component per diem for a nursing facility shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index to be calculated quarterly, and the regional wage adjustor. Transition rates for services provided between January 1, 2014 and December 31, 2014, shall be as follows:
- A) The transition RUG-IV per diem nursing rate for nursing facilities whose rate calculated in this subsection (f) is greater than the nursing component rate in effect July 1, 2012, shall be paid the sum of:
- i) The nursing component rate in effect July 1, 2012; plus
- ii) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012, multiplied by 0.88.

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- B) The transition RUG-IV per diem nursing rate for nursing facilities whose rate calculated in this subsection (f) is less than the nursing component rate in effect July 1, 2012, shall be paid the sum of:
- i) The nursing component rate in effect July 1, 2012; plus
 - ii) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012, multiplied by 0.13.
- 2) Effective for dates of service on or after July 1, 2014, a per diem add-on to the RUGS methodology will be included as follows:
- A) \$0.63 for each resident who scores I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.
 - B) \$2.67 for each resident who scores "1" or "2" in any items S1200A through S1200I and also scores in the RUG groups PA1, PA2, BA1 and BA2.
- ~~Effective for dates of service on or after January 1, 2015, subject to the requirement of P.A. 98-0104 that the Department submit a rule by January 1, 2014, which establishes a reimbursement methodology that is reflective of the intensity of care and services requirements of the low need residents in the lowest RUG-IV groups, the Department will calculate quarterly the value of a per diem increase of \$1.00 multiplied by 365 divided by total facility resident days for each resident reporting in the low four RUG groups PA1, PA2, BA1 or BA2, as of September 30, 2013. The value of this increase will be applied to the per diem rate of each nursing facility in which total resident occupancy is at least 70 percent Medicaid on a quarterly basis.~~
- 3) The Department shall determine the group to which a resident is assigned using the 48-group RUG-IV classification scheme with an index maximization approach. A resident for whom RUGs resident identification information is missing, or inaccurate, or for whom there is no current MDS record for that quarter, shall be assigned to default group AA1. A resident for whom an MDS assessment does not meet the federal

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CMS edit requirements as described in the Long Term Care Resident Assessment Instrument (RAI) Users Manual or for whom an MDS assessment has not been submitted within 14 calendar days after the time requirements in Section 147.315 shall be assigned to default group AA1.

- 4) The assessment used for the purpose of rate calculation shall be identified as an Omnibus Budget Reconciliation Act (OBRA) assessment on the MDS following the guidance in the RAI Manual.
- 5) The MDS used for the purpose of rate calculation shall be determined by the Assessment Reference Date (ARD) identified on the MDS assessment.
- g) The Department shall provide each nursing facility with information that identifies the group to which each resident has been assigned.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 147.335 Enhanced Care Rates

An additional enhance rate is applied for certain categories of residents that are in need of more resources.

- a) Ventilator Services – The following criteria shall be met to be eligible for enhanced rates.
 - 1) Ventilators are defined as any type of electrical or pneumatically powered closed mechanical system for residents who are, or who may become, unable to support their own respiration. It does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BiPAP) devices. When ventilators are used to deliver CPAP or BiPAP they shall not be counted as ventilator services for enhanced rates.
 - 2) Ventilators set to PEEP or CPAP to aid in weaning a resident from the ventilator are included. The weaning process shall be documented in the clinical record. Ventilators used to deliver CPAP or BiPAP services for the resident with Sleep Apnea are not included.
 - 3) Nursing facility shall notify the Department using a Department designated form that includes a physician order sheet that identifies the

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need and delivery of ventilator services. A facility shall also use the designated form to notify the Department when a resident is no longer receiving ventilator services. In addition, a Section S item response of the MDS may be used.

- 4) The following criteria shall be met in order for a facility to qualify for ventilator care reimbursement.
 - A) A facility shall establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.
 - B) Facilities shall be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.
 - C) Clinical assessment of oxygenation and ventilation-arterial blood gases or other methods of monitoring carbon dioxide and oxygenation shall be available on-site for the management of residents. Documentation shall support clinical monitoring of oxygenation stability was completed at least twice a day.
 - D) Emergency and life support equipment, including mechanical ventilators, shall be connected to electrical outlets with back-up generator power in the event of a power failure.
 - E) Ventilators shall be equipped with internal batteries to provide a short term back-up system in case of a total loss of power.
 - F) An audible, redundant ventilator alarm system shall be required to alert staff of a ventilator malfunction, failure or resident disconnect. A back-up ventilator shall be available at all times.
 - G) Facilities licensed under the Nursing Home Care Act shall have a minimum of one RN on duty for 8 consecutive hours, 7 days per week, as required by 77 Ill. Adm. Code 300.1240. For facilities licensed under the Hospital Licensing Act, an RN shall be on duty at all times, as required by 77 Ill. Adm. Code 250.910. Additional RN staff may be determined necessary by the Department, based on the Department's review of the ventilator services.

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- H) Licensed nursing staff shall be on duty in sufficient numbers to meet the needs of residents as required by 77 Ill. Adm. Code 300.1230. For facilities licensed under the Nursing Home Care Act, the Department requires that an RN shall be on call, if not on duty, at all times.
- I) No less than one licensed respiratory care practitioner licensed in Illinois shall be available at the facility or on call 24-hours a day to provide care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing as determined by the needs and number of the residents being served by a facility. The practitioner shall evaluate and document the respiratory status of a ventilator resident on no less than a weekly basis.
- J) A pulmonologist, or physician experienced in the management of ventilator care, shall direct the care plan for ventilator residents on no less than a twice per week basis.
- K) At least one of the full-time licensed nursing staff members shall have successfully completed a course in the care of ventilator dependent individuals and the use of the ventilators, conducted and documented by a licensed respiratory care practitioner or a qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals.
- L) All staff caring for ventilator dependent residents shall have documented in-service training in ventilator care prior to providing such care. In-service training shall be conducted at least annually by a licensed respiratory care practitioner or qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals. Training shall include, but is not limited to, status and needs of the resident, infection control techniques, communicating with the ventilator resident, and assisting the resident with activities. In-service training documentation shall include name and title of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.

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- M) Documentation shall support the resident has a health condition that requires medical supervision 24-hours a day of licensed nursing care and specialized services or equipment.
 - N) The medical records shall contain physician's orders for respiratory care that includes, but is not limited to, diagnosis, ventilator settings, tracheostomy care and suctioning, when applicable.
 - O) Documentation shall support the resident receive tracheostomy care at least daily.
- 5) To be eligible to receive ventilator add-on, facilities shall also be required to implement the established written protocols on the following areas:
- A) Pressure Ulcers. A facility shall have established policies and procedures on assessing, monitoring and prevention of pressure ulcers, including development of a method of monitoring the occurrence of pressure ulcers. Staff shall receive in-service training on those areas.
 - i) Documentation shall support the resident has been assessed quarterly for their risk for developing pressure ulcers.
 - ii) Documentation shall support that interventions for pressure ulcer prevention were implemented and include, but are not limited to, a turning and repositioning schedule, use of pressuring reducing devices, hydration and nutritional interventions and daily skin checks.
 - B) Pain. A facility shall have established policies and procedures on assessing the occurrence of pain, including development of a method of monitoring the occurrence of pain. Staff shall receive in-service training on this area.
 - i) Documentation shall support the resident has been assessed quarterly for the presence of pain and the risk factors for developing pain.

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- ii) Documentation shall support an effective pain management regime is in place for the resident.
- C) Immobility. A facility shall have established policies and procedures to assess the possible effects of immobility. These shall include, but not be limited to, range of motion techniques, contracture risk. Staff shall receive in-service training on this area.
 - i) Documentation shall support the resident's risk for contractures were assessed quarterly and interventions are in place to reduce the risk.
 - ii) Effects of immobility will be monitored and interventions implemented as needed.
- D) Risk of infection. A facility shall have established policies and procedures on assessing risk for developing infection and prevention techniques. These shall include, but are not limited to proper hand washing techniques, aseptic technique in delivery care to a resident, and proper care of equipment and supplies. Staff shall receive in-service training on this area.
 - i) Documentation shall support the resident was given oral care every shift to reduce the risk of infection.
 - ii) Documentation shall support the facility has a method to monitor and track infections.
- E) Social Isolation. A facility shall have a method of assessing a resident's risk for social isolation. Interventions shall be in place to involve a resident in activities when possible.
- F) Ventilator Weaning. A facility shall have a method of routinely assessing a resident's weaning potential and interventions implemented as needed. Documentation shall support the weaning process and the use of mechanical ventilation for a portion of each day for stabilization.

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- G) Policies shall include monitoring expectations of the ventilator resident, routine maintenance of equipment and specific staff training related to ventilator settings and care.
 - H) In order to maintain quality standards and reduce cross contamination, the facility shall have a policy for cleaning and maintaining equipment.
- 6) Department staff shall conduct on-site visits on a random or targeted basis to ensure both facility and resident compliance with requirements. All records shall be accessible to determine that the needs of a resident are being met and to determine the appropriateness of ventilator services. In addition to the requirements of this subsection, Department review shall include, at a minimum, the following:
- A) The tracking of Ventilator Associated Pneumonia;
 - B) Documentation to track hospitalizations, reason for hospitalizations, and interventions aimed at reducing hospitalizations for ventilator residents;
 - C) Ventilator weaning;
- 7) An enhanced payment shall be added to the rate determined by the methodology currently in place:
- A) Payment shall be made for each individual resident receiving ventilator services;
 - B) The rate add-on for ventilator service is \$208 per day.
- b) Traumatic Brain Injury (TBI) – The following criteria shall be met to be eligible for enhanced rates.
- 1) A facility shall meet all the criteria set forth in this subsection for TBI care to a resident in order to receive the enhanced TBI reimbursement rate identified.

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- 2) TBI is a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.
- 3) The following criteria shall be met in order for a facility to qualify for TBI reimbursement.
 - A) The facility shall have written policies and procedures for care of the residents with TBI and behaviors that include, but are not limited to, monitoring for behaviors, identification and reduction of agitation, safe and effective interventions for behaviors, and assessment of risk factors for behaviors related to safety of residents, staff and staff shall be in-serviced on these policies.
 - B) The facility shall have staff to complete the required physical (PT), occupational (OT) or speech therapy (SP), as needed. Additionally, a facility shall have staffing sufficient to meet the behavior, physical and psychosocial needs of the resident.
 - C) Staff shall receive in-service for the care of a TBI resident and dealing with behavior issues identifying and reducing agitation, and rehabilitation for the TBI resident. In-service training shall be conducted at least annually. In-service documentation shall include name and title of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.
 - D) The facility environment shall be such that it is aimed at reducing distractions for the TBI resident during activities and therapies. This shall include, but not be limited to, avoiding overcrowding, loud noises, lack of privacy, seclusion and social isolation.
 - E) Care plans on all residents shall address the physical, behavioral and psychosocial needs of the TBI residents. Care plans shall be individualized to meet the resident's needs, and shall be revised as necessary.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- F) The facility shall use the "Rancho Los Amigos Cognitive Scale" to determine the level of cognitive functioning. The assessment shall be completed quarterly by a trained rehabilitation registered nurse. Based on the level of functioning, and the services and interventions implemented, a resident will be placed in 1 of 3 tiers of payments. Tier 3 is the highest reimbursement. By completing a Department designated form, facilities will be responsible for notifying the Department of the applicable tier in which a resident is placed.
 - G) Documentation found elsewhere in the resident records shall support the scoring on the Rancho Los Amigos Scale as well as the delivery of coded interventions.
- 4) Admission Criteria
- A) Documentation by a neurologist that the resident has a severe and extensive TBI diagnosis.
 - B) The diagnosis meets RAI Manual requirements for coding.
 - C) There shall be documentation the diagnosis has resulted in significant deficits and disabilities that required intense rehabilitation therapy. In addition, documentation from the neurologist shall identify the resident has the ability to benefit from rehabilitation and a potential for independent living.
 - D) Diagnostic testing shall support the presence of a severe and extensive TBI as a result of external force as defined in subsection (b)(2).
 - E) Documentation the resident was assessed using the Rancho Los Amigos Cognitive Scale and scored a Level IV-X. Residents scoring a Level I, II or III on the Rancho Los Amigos Cognitive Scale shall not be eligible for TBI reimbursement.
 - F) Documentation the resident is medically stable and has been assessed for potential behaviors and safety risk to self, staff and others.

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- 5) Documentation supports the Tier I requirements are as follows:
- A) Tier I shall not exceed 6 months.
 - B) The resident shall have previously scored in Tier II or Tier III.
 - C) The resident has received intensive rehabilitation and is preparing for discharge to the community. The resident shall receive intervention and training focusing on independent living skills, prevocational training and employment support. This includes, but is not limited to, community support options, substance abuse counseling, as appropriate, time management and goal setting.
 - D) Resident scores a Level VIII-X on the Rancho Los Amigos Cognitive Scale (Purposeful, Appropriate, and stand-by assistance to Modified Independence).
 - E) No behaviors or Behaviors present, but less than 4 days (E0200A-C<2 AND E0500A-C=0 AND E0800< 2 and E1000A+B=0). If behaviors are present, resident receives behavior management training to address the specific behaviors identified.
 - F) Cognition. Brief Interview for Mental Status (BIMS) is 13-15 (Cognitively intact, C0500).
 - G) Activities of daily living (ADL) functioning. All ADL tasks shall be coded less than 3 (Section G).
 - H) An assessment shall be completed quarterly to identify the resident's needs and risk factors related to independent living. This assessment shall include, but is not limited to, physical development and mobility, communication skills, cognition level, food preparation and eating behaviors, personal hygiene and grooming, health and safety issues, social and behavioral issues, ADL potential with household chores, transportation, vocational skills and money management.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- I) Discharge Potential. There is an active discharge plan in place (Q0400A=1) or referral has been made to the local contact agency (Q0600=1). There shall be weekly documentation by a licensed social worker related to discharge potential and progress. This shall include working with the resident on community resources and prevocational employment options.
 - J) The resident shall receive interventions and/or training related to their specific discharge needs.
- 6) Documentation supports the Tier II requirements are as follows:
- A) Tier II shall not exceed 12 months.
 - B) Resident has reached a plateau in rehabilitation ability, but still requires services related to the TBI. Resident shall have previously scored in Tier III. The resident continues to receive restorative nursing services.
 - C) Resident scores a Level IV-VII on the Rancho Los Amigos Cognitive Scale (Confusion, may or may not be appropriate).
 - D) Cognition. BIMS is less than 13 (C0500) or Cognitive Skills for decision making are moderately to severely impaired (C1000=2 or 3).
 - E) Resident has behaviors (E0300=1 or E1000=1) and these behaviors impact resident (E0500A-C=1) or impact others (E0600A-C=1). Behaviors shall be tracked daily and interventions implemented. There shall be documentation of weekly meetings with interdisciplinary staff to discuss behaviors, effectiveness of interventions and to implement revisions as necessary.
 - F) ADL function (Section G) 3 or more ADL require limited or extensive assistance.
 - G) Resident is on 2 or more of the following restorative: Bed Mobility (O0500D=1), Transfer (O0500E=1), Walking (O0500F=1),

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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Dressing/Grooming (O0500G=1), Eating (O0500H=1) or Communication (O0500J=1).

- H) Resident receives either Psychological (O0400E2>1) or Recreational Therapy (O0400F2>1) at least 2 or more days a week. Documentation shall include a summary of the sessions, resident's progress and potential goals, and identify any revisions needed.
 - I) Documentation shall support one to one meeting with a licensed social worker at least twice a week to discuss potential needs, goals and any behavior issues.
 - J) Documentation of at least quarterly oversight of care plan by a neurologist.
 - K) Documentation the resident has received instruction and training at least twice per week that includes, but is not limited to, behavior modification, anger management, time management goal setting, life skills and social skills.
 - L) Behavioral rehabilitation assessment and evaluations shall be completed quarterly and shall include cognition, behaviors, interventions and outcomes.
 - M) Documentation shall support the residents requires intensive counseling, behavioral management and neuro-cognitive therapy. The resident behaves in such a manner as to indicate an inability, without ongoing supervision and assistance of others, they would be unable to satisfy the need for nourishment, personal care, medical care, shelter, self-protection and safety.
- 7) Documentation supports the Tier III requirements are as follows:
- A) Tier III shall not exceed 9 months.
 - B) The injury resulting in a TBI diagnosis must have occurred within the prior 6 months to score in Tier III.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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- C) Includes the acutely diagnosed resident with extensive deficits in physical functioning and identifies intensive rehabilitation needs.
- D) Resident scores an IV-VII on the Rancho Los Amigos Cognitive Scale.
- E) Cognition. BIMS is less than 13 (C0500) or Cognitive Skills for decision making are moderately to severely impaired (C1000=2 or 3).
- F) Documentation shall support the facility is monitoring behaviors and has implemented interventions to identify the risk factors for behaviors and to reduce the occurrence of behaviors.
- G) Resident receives Rehabilitation therapy (PT, OT or ST) at least 500 minutes per week and at least one rehabilitation discipline 5 days per week (O0400). The therapy shall meet the RAI Manual guidelines for coding. The resident shall continue to show the potential for improvement in the therapy programs.
- H) The facility shall have trained rehabilitation staff on-site working with the resident on a daily basis. This shall include a trained rehabilitation nurse and rehabilitation aides. The resident requires a minimum of 6 to 8 hours per day of one-to-one support as a result of functional issues.
- I) Documentation shall support there are weekly meetings of the interdisciplinary team to discuss the resident's rehabilitation progress and potential.
- J) Resident receives Psychological Therapy (O0400E2>1) at least 2 days per week. Documentation shall include a summary of the sessions, resident's progress and potential goals, and identify any revisions needed.
- K) There shall be documentation to support monthly oversight by a neurologist.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- L) A comprehensive medical and neuro-psychological assessment is done upon admission and quarterly. It shall include, but is not limited to, the following:
- i) Physical ability and mobility;
 - ii) Motor coordination;
 - iii) Hearing, vision and speech;
 - iv) Behavior and impulse control;
 - v) Social functionality;
 - vi) Cognition;
 - vii) Safety and medical needs; and
 - viii) Communication needs.
- 8) Rates of payment for each Tier are as follows:
- A) The payment amount for Tier I is \$264.17 per day.
 - B) The payment amount for Tier II is \$486.49 per day.
 - C) The payment amount for Tier III is \$767.46 per day.
- 9) Effective for services on or after January 1, 2015, facilities licensed by the Department of Public Health under the Nursing Home Care Act and meeting all the care and services requirements of this Part will receive a per diem add-on of \$5.00 for each resident scoring as TBI on the MDS 3.0 but otherwise not qualifying for Tier 1, 2 or 3.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Long Term Care Reimbursement Changes
- 2) Code Citation: 89 Ill. Adm. Code 153
- 3) Section Number: 153.126 Proposed Action:
Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5]
- 5) Complete Description of the Subject and Issues Involved: Pursuant to PA 98-651, this rulemaking makes changes to the support component of the rates of certain nursing facilities and, with respect to long-term care facilities for persons under 22 years of age serving clinically complex residents, defines these facilities, places them on an expedited payment schedule, establishes per diem rates, and defines clinically complex persons under 22 years of age.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule currently in effect? Yes
- 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 Objective: This rulemaking does not affect units of local government.
- 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., 3rd Floor
Springfield IL 62763-0002

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

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: Medicaid funded providers
 - 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: This rulemaking was not anticipated by the Department when the most recent regulatory agendas were published.

The full text of the Proposed Amendment is identical to the Emergency Rule that begins on page 15732.

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Procedure for Conducting Examinations of Persons Seeking Certificates of Competency
- 2) Code Citation: 62 Ill. Adm. Code 230
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
230.30	Amendment
230.40	New Section
- 4) Statutory Authority: Implementing and authorized by Articles 2 and 3 of the Coal Mining Act [225 ILCS 705/Art. 2 and 3]
- 5) A Complete Description of the Subjects and Issues Involved: PA 98-543 gave the Office of Mines and Minerals authority to issue certificates of competency for mine electricians. Existing administrative rules do not contain the procedures or specifics for application and examination of candidates. This Part is being amended to incorporate eligibility requirements for obtaining mine electrician certification, how and when the mine electrician examination will be administered, examination and training requirements for mine electricians from other states, and parameters for cancellation, revocation or suspension of mine electrician certification.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule 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 Objective: 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:

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Nick San Diego, Legal Counsel
Department of Natural Resources
One Natural Resources Way
Springfield IL 62702-1271

217/782-1809

- 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: July 2014

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

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

TITLE 62: MINING

CHAPTER I: DEPARTMENT OF NATURAL RESOURCES

PART 230

PROCEDURE FOR CONDUCTING EXAMINATIONS OF
PERSONS SEEKING CERTIFICATES OF COMPETENCY

Section

230.10	Procedure for Holding Semi-Annual Mining Board Examinations
230.20	Procedure for Conducting Examinations Other Than the Semi-Annual Mining Board Examinations
230.30	Fees for Certificates of Competency
230.40	Procedure for Conducting Mine Electrician Examinations

AUTHORITY: Implementing and authorized by Article 2 and 3 of the Coal Mining Act [225 ILCS 705/Arts. 2 and 3].

SOURCE: Filed and effective June 17, 1958; codified at 7 Ill. Reg. 9305; amended at 37 Ill. Reg. 6772, effective May 1, 2013; amended at 38 Ill. Reg. _____, effective _____.

Section 230.30 Fees for Certificates of Competency

The following fees shall be paid to the Department for administration of certificate examinations and are non-refundable.

- a) Applicants shall submit, along with the application, the following fee for each examination.

Certificate of Competency	Fee
State Mine Inspector	\$50
Mine Manager	\$50
Mine Examiner	\$50
Electrical Hoisting Engineer	\$50
General Surface Supervisor	\$50
Independent Contractor Supervisor	\$50
Shaft-Slope Supervisor	\$50
Shaft-Slope Examiner	\$50

DEPARTMENT OF NATURAL RESOURCES

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Surface Mine Supervisor	\$50
Shot Firer	\$50
First Class	\$50
Shaft-Slope Worker	\$50
Crane Hoist Operator	\$50
<u>Mine Electrician</u>	<u>\$50</u>

- b) The fee for a temporary Certificate of Competency is \$50.
- c) The fee for annual renewal of Mine Electrician certification is \$25.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 230.40 Procedure for Conducting Mine Electrician Examinations

- a) Candidates seeking Certificates of Competency as Mine Electricians must complete an application provided by the Department and provide evidence of at least one year of experience in performing electrical work in a coal mine or acceptable related industry and take an Illinois Mine Electrical Examination.
- 1) Evidence of experience must include details of electrical work, including but not limited to: dates of work, work performed and types of equipment upon which electrical work was conducted and the names of persons supervising the work.
 - 2) An acceptable related industry can be one of the following: a non-coal mine, mine equipment manufacturing industry or any other industry using or manufacturing similar equipment.
- b) Illinois Mine Electrical Examinations for Certificates of Competency as Mine Electricians will be in three categories:
- 1) Coal Mine Electrician – Surface and Underground;
 - 2) Coal Mine Electrician – Surface Only; and
 - 3) Coal Mine Electrician – Underground Only.

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

- c) Candidates must submit to the Department evidence of eligibility at least 30 days prior to the scheduled examination.
- d) Examinations will be conducted at least twice a year and additional examinations will be scheduled if needed. A public notice shall be given through the press or otherwise, not less than 10 days in advance, announcing the time and date for the examination.
- e) Candidates may be eligible to take the Illinois Mine Electrical Examination if the candidate:
 - 1) Is classified as an Apprentice Mine Electrician and have met the requirements for an apprentice.
 - A) An Apprentice Mine Electrician is an individual who has successfully completed the Illinois Basic Electrical Safety Training (IBEST), has completed or is in the process of completing the Illinois Initial Mine Electrical Training program and is in or has completed an approved Coal Mine Maintenance Training Program.
 - B) The IBEST is an 8-hour safety class approved by the Department. Satisfactory completion of the class requires attaining a minimum score of 80% on a written examination.
 - C) The Illinois Initial Mine Electrical Training Program is a 112-hour program approved by the Department that includes, but is not limited to: DC Theory, AC Theory, Mine Electrical Equipment, Permissibility, and State and Federal Regulations.
 - D) The Coal Mine Maintenance Training Program is a program approved by the Department in which the Apprentice Mine Electrician is working as a maintenance person. A log is kept of electrical repair and maintenance activities;
 - 2) Possesses a Bachelor of Science degree in electrical engineering and provides proof of electrical experience as outlined in subsection (a)(1); or

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

- 3) Is qualified as a mine electrician but has not taken the examinations required in 30 CFR 75.153(a) and 77.103(a)(3).
- f) The examination will be in three parts: written, oral and practical. The candidate must attain a minimum score of 80% on the written examination. The practical and oral examinations are pass/fail. The practical and oral examinations may be scheduled separately from the written examination.
- g) Candidates failing to achieve 80% on any portion of the written examination will be given two additional opportunities to retake and pass the failed portion. Candidates failing the practical or oral examination will be given one additional opportunity to pass the failed examination. Candidates wishing to retake a failed portion of the written examination or the practical or oral examination may do so at the next subsequent scheduled examination.
- h) Candidates failing to achieve a passing grade on the written, practical or oral examinations after the allotted number of opportunities to retake the examination will be required to retake the entire examination.
- i) A Certificate of Competency will be provided to a candidate upon successfully passing all three examination parts.
- j) An Illinois Mine Electrical Examination is not required if an individual possesses a current coal mine electrical certification from a Mine Safety and Health Administration (MSHA)-approved State coal mine electrical program or holds an MSHA electrical qualification card. These candidates must complete an 8-hour IBEST class provided by an Illinois-approved electrical instructor and attain a minimum score of 80% on a written examination administered by a representative from the Department. The written examination is 30 questions pertaining to State laws/regulations and arc flash. A Certification of Competency will be provided to the candidate upon completion of the class and successfully passing the written examination.
- k) A person possessing a current coal mine electrical certification from an MSHA-approved State coal mine electrical program or holding an MSHA electrical qualification card may receive temporary certification as a Mine Electrician until the next 8-hour electrical safety IBEST class and until the required examination has been administered by a representative from the Department.

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

- l) To maintain Illinois Mine Electrician certification, an individual must annually complete an 8-hour electrical refresher class provided by an Illinois-approved electrical instructor and a renewal fee must be paid to the Department either prior to or at the time of the class.
- 1) An individual who fails to attend the required annual refresher training will have his/her certification revoked.
- 2) To reinstate the Illinois Mine Electrician certification, an individual is required to comply with subsection (j).
- m) Illinois Mine Electrician certification may be cancelled, revoked or suspended by the Illinois State Mining Board if it is established the holder of the certification has obtained the certification by fraud or misrepresentation of experience or becomes unworthy of certification by reason of violation of the law or regulation, intemperate habits, incapacity, abuse of authority or any other cause. The person against whom charges or complaints are made shall have the right to appear before the State Mining Board (see 62 Ill. Adm. Code 100).
- n) Persons employed in the Illinois coal industry on January 1, 2014 who hold an MSHA electrical qualification card are exempt from the requirements of this Section until their first annual refresher class under subsection (l). Upon completion of the annual refresher class, individuals who wish to obtain Illinois Mine Electrician certification will receive an application. The completed application and fee shall be submitted to the Department and a Certificate of Competency as Mine Electrician will be issued.

(Source: Added at 38 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Prohibited Conduct
- 2) Code Citation: 11 Ill. Adm. Code 423
- 3) Section Number: 423.10 Proposed Action:
New Section
- 4) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]
- 5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking adds Section 423.10, which suspends licensees (both harness and thoroughbred) who pay an obligation to the Board (i.e. check) that is returned by the bank unpaid (NSF), until the amount is paid in full. This provision is being repealed from 11 Ill. Adm. Code 1322 (Fines, Suspension, and Expulsion) and added to this Part because it applies to both harness and thoroughbred licensees.
- 6) Published studies or reports and sources of underlying data used to compose this rulemaking: None
- 7) Will this proposed rulemaking replace any emergency rule 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 Objective: No local governmental units will be required to increase expenditures.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 5-700

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

Chicago IL 60601

312/814-5017

- 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: July 2013

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

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER b: RULES APPLICABLE TO ORGANIZATION LICENSEES

PART 423
PROHIBITED CONDUCT

Section

423.10	Dishonored Check
423.20	Sale of Products
423.30	Political Contributions

AUTHORITY: Implementing and authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: 5 Ill. Reg. 8833, effective August 25, 1981; codified at 5 Ill. Reg. 10636; emergency amendment at 5 Ill. Reg. 11593, effective October 20, 1981, for a maximum of 150 days; emergency expired March 17, 1982; amended at 6 Ill. Reg. 10714, effective August 20, 1982; amended at 7 Ill. Reg. 10782, effective August 24, 1983; amended at 7 Ill. Reg. 16098, effective November 22, 1983; amended at 8 Ill. Reg. 21593, effective October 23, 1984; amended at 9 Ill. Reg. 16204, effective October 9, 1985; emergency amendment at 9 Ill. Reg. 18151, effective November 12, 1985, for a maximum of 150 days; emergency expired April 11, 1986; amended at 10 Ill. Reg. 16649, effective September 22, 1986; amended at 11 Ill. Reg. 9540, effective May 5, 1987; amended at 12 Ill. Reg. 11730, effective June 30, 1988; amended at 13 Ill. Reg. 10598, effective June 19, 1989; amended at 14 Ill. Reg. 10798, effective June 20, 1990; amended at 15 Ill. Reg. 11598, effective August 2, 1991; amended at 16 Ill. Reg. 11078, effective June 30, 1992; amended at 17 Ill. Reg. 10795, effective July 1, 1993; amended at 18 Ill. Reg. 10090, effective June 21, 1994; amended at 19 Ill. Reg. 11787, effective August 3, 1995; amended at 20 Ill. Reg. 10874, effective August 5, 1996; amended at 21 Ill. Reg. 9077, effective June 26, 1997; amended at 22 Ill. Reg. 14836, effective August 3, 1998; amended at 23 Ill. Reg. 9066, effective July 28, 1999; amended at 24 Ill. Reg. 8938, effective June 19, 2000; amended at 25 Ill. Reg. 9895, effective July 17, 2001; amended at 26 Ill. Reg. 14680, effective September 20, 2002; amended at 28 Ill. Reg. 11873, effective July 27, 2004; amended at 29 Ill. Reg. 8409, effective June 1, 2005; amended at 38 Ill. Reg. _____, effective _____.

[Section 423.10 Dishonored Check](#)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

A licensee who pays a license fee, fine or other claim to the Board with a check, cashier's check or money order that is returned unpaid or dishonored shall be suspended until the amount of the check, cashier's check or money order is paid in full.

(Source: Added at 38 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

312/814-5017

- 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: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

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

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER f: RULES AND REGULATIONS OF HARNESS RACING

PART 1322
FINES, SUSPENSION, AND EXPULSION

Section

1322.10	Suspension Until Paid
1322.20	Fines and Penalties Recorded
1322.30	Definition of Suspension
1322.40	No Right to Compete
1322.50	Fraudulent Transfer
1322.60	Track Enforcement of Penalties
1322.70	Use of Track Grounds
1322.80	Exclusion
1322.90	Track Officers
1322.100	Dishonored Check <u>(Repealed)</u>

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Harness Racing, (original date not cited in publication); codified at 5 Ill. Reg. 10950; amended at 38 Ill. Reg. _____, effective _____.

Section 1322.100 Dishonored Check (Repealed)

~~Any person who pays an entry, a fine or other claim to the Board by a draft, check, order or other paper, which upon presentation is protested, payment refused or otherwise dishonored, shall be subject to a fine not exceeding the amount of said draft, check, or order. Said persons and horses shall be suspended until the dishonored amount and fine are paid.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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

<u>Section Numbers:</u>	<u>Adopted Action:</u>
310.50	Amendment
310.100	Amendment
310.130	Amendment
310.260	Amendment
310.500	Amendment
310.APPENDIX A TABLE A	Amendment
310.APPENDIX A TABLE B	Amendment
310.APPENDIX A TABLE C	Amendment
310.APPENDIX A TABLE D	Amendment
310.APPENDIX A TABLE E	Amendment
310.APPENDIX A TABLE F	Amendment
310.APPENDIX A TABLE G	Amendment
310.APPENDIX A TABLE H	Amendment
310.APPENDIX A TABLE I	Amendment
310.APPENDIX A TABLE J	Amendment
310.APPENDIX A TABLE K	Amendment
310.APPENDIX A TABLE M	Amendment
310.APPENDIX A TABLE N	Amendment
310.APPENDIX A TABLE O	Amendment
310.APPENDIX A TABLE P	Amendment
310.APPENDIX A TABLE Q	Amendment
310.APPENDIX A TABLE R	Amendment
310.APPENDIX A TABLE S	Amendment
310.APPENDIX A TABLE T	Amendment
310.APPENDIX A TABLE V	Amendment
310.APPENDIX A TABLE W	Amendment
310.APPENDIX A TABLE X	Amendment
310.APPENDIX A TABLE Y	Amendment
310.APPENDIX A TABLE Z	Amendment
310.APPENDIX A TABLE AC	Amendment
310.APPENDIX A TABLE AD	Amendment

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

- 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 Rule: July 1, 2014
- 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 rule, including any material incorporated by reference, is on file in the Agency's principal office and is available for public inspection. Copies of all Pay Plan amendments and collective bargaining contracts are available upon request from the Division of Technical Services and Agency Training and Development.
- 9) Notices of Proposed published in the *Illinois Register*: 38 Ill. Reg. 6751; March 28, 2014
- 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 three intervening rulemakings, an Illinois Labor Relations Board (ILRB) Certification of Unit Clarification, changes provided by JCAR staff in the delta version and CMS recommendations. The First Notice Changes are the following:

The Main Source Notes contain the references to the emergency amendment filed April 11, 2014, the preemptory amendments filed April 11, 2014 and the adopted amendments filed April 21, 2014.

Section 310.100 contains formatting changes and intervening rulemaking's text. In particular, the original amendment to subsection (1)(2) is modified based on the intervening rulemaking.

Section 310.260 contains a change noting "pending negotiations" in the Negotiated Pay Grade column for the Corrections Nurse Trainee title based on the below-referenced Certification and other changes based on intervening rulemaking. The ILRB Certification of Unit Clarification (Case No. S-UC-(S)-14-044) to include the Corrections Nurse Trainee title in the RC-023 (Illinois Nurses Association) bargaining unit issued April 4, 2014 is provided as background for the change related to the title in Section 310.260.

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Section 310.500 contains intervening rulemaking's formatting and text.

Sections 310.Appendix A Tables A, B, C, D, E, F, G, H, I, J, K, M, N, O, P, Q, R, S, T, V, W, X, Y, Z, AC and AD contains formatting changes and intervening rulemaking text.

Very minor formatting changes introduced for consistency throughout the Pay Plan are contained in Sections 310.Appendix A Tables B, D, E, G, K, P, T, W, Y, Z, AC and AD.

In addition, one intervening preemptory amendment was adopted. The Main Source Notes contain reference to the preemptory amendment. In Section 310.Appendix A Table J and to the title table, the Human Resources Trainee title (Department of Revenue), its title code 19694, bargaining unit and pay grade are added.

- 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 rule currently in effect? No
- 14) Are there any rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
310.Appendix A Table X	Amendment	38 Ill. Reg. 8507; April 25, 2014
310.100	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table A	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table D	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table E	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table F	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table X	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.410	Amendment	38 Ill. Reg. 13489; July 7, 2014
310.Appendix A Table A	Amendment	38 Ill. Reg. 13489; July 7, 2014
310.Appendix A Table W	Amendment	38 Ill. Reg. 13489; July 7, 2014
310.Appendix A Table AE	Amendment	38 Ill. Reg. 13489; July 7, 2014

- 15) Summary and Purpose of Rulemaking: In Section 310.50 and Divided Class definition, the effective date of the divided class list is updated and the Engineering Technician IV,

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Heavy Construction Equipment Operator and Internal Security Investigator I and II titles are added.

In Sections 310.50 and 310.500 and Option definition, the Public Service Administrator Options 6B, 8J, 8X and 9T are removed and the Senior Public Service Administrator Option 2A is added.

In Section 310.100 subsection (1)(2), the Section 310.Appendix A Table A (RC-104) is added because the Section's Note contains the longevity pay provision from the contract signed February 4, 2014. This change will be combined with related changes in the proposed amendments at 38 Ill. Reg. 196.

In Section 310.130, the Fiscal Year is updated to 2015.

In Section 310.260, the Corrections Nurse Trainee and Firearms Eligibility Analyst Trainee titles are added to the list of Trainee Program classifications.

In Section 310.Appendix A Table A, the last day that the Senior Public Service Administrator title, Option 7 (captain function) Department of Natural Resources positions were represented by RC-104 is added in the title table and Note. A rate table effective October 7, 2013 is added. The Senior Public Service Administrator title, Option 7 (captain function) Department of Natural Resources positions were excluded from collective bargaining representation effective October 7, 2013 when the Illinois Labor Relations Board issued the Corrected Certification of Gubernatorial Designation of Positions Excluded from Collective Bargaining (Case No. S-DE-14-096).

In Section 310.Appendix A Table B, C, D, E, F, G, H, I, J, K, M, N, O, P, Q, R, S, T, V, W, X, Y, Z, AC and AD, the rates or rate tables no longer in effect are removed.

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

Mr. Jason Doggett, 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

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Springfield IL 62706

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:

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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-Hire 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
310.270	Legislated Rate

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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	
310.600	Jurisdiction (Repealed)
310.610	Pay Schedules (Repealed)

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310.620	In-Hiring Rate (Repealed)
310.630	Definitions (Repealed)
310.640	Increases in Pay (Repealed)
310.650	Other Pay Provisions (Repealed)
310.660	Effective Date (Repealed)
310.670	Negotiated Rate (Repealed)
310.680	Trainee Rate (Repealed)
310.690	Educator Schedule for Frozen RC-063 and Frozen HR-010 (Repealed)
310.APPENDIX A	Negotiated Rates of Pay
310.TABLE A	RC-104 (Conservation Police Supervisors, Illinois Fraternal Order of Police Labor Council)
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)
310.TABLE T	HR-010 (Teachers of Deaf, IFT)

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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 (Blasting Experts, Blasting Specialists and Blasting Supervisors 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 (Repealed)
310.TABLE A	Frozen RC-104-Rates-of-Pay (Conservation Police Supervisors, Laborers' – ISEA Local #2002) (Repealed)
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) (Repealed)
310.TABLE H	Frozen RC-006-Rates-of-Pay (Corrections Employees, AFSCME) (Repealed)
310.TABLE I	Frozen RC-009-Rates-of-Pay (Institutional Employees, AFSCME) (Repealed)
310.TABLE J	Frozen RC-014-Rates-of-Pay (Clerical Employees, AFSCME) (Repealed)
310.TABLE K	Frozen RC-023-Rates-of-Pay (Registered Nurses, INA) (Repealed)
310.TABLE M	Frozen RC-110-Rates-of-Pay (Conservation Police Lodge) (Repealed)
310.TABLE N	Frozen RC-010 (Professional Legal Unit, AFSCME) (Repealed)
310.TABLE O	Frozen RC-028-Rates-of-Pay (Paraprofessional Human Services Employees, AFSCME) (Repealed)
310.TABLE P	Frozen RC-029-Rates-of-Pay (Paraprofessional Investigatory and Law Enforcement Employees, IFPE) (Repealed)
310.TABLE R	Frozen RC-042-Rates-of-Pay (Residual Maintenance Workers,

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310.TABLE S	AFSCME) (Repealed) Frozen VR-704-Rates-of-Pay (Departments of Corrections, Financial and Professional Regulation, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002) (Repealed)
310.TABLE T	Frozen HR-010-Rates-of-Pay (Teachers of Deaf, IFT) (Repealed)
310.TABLE V	Frozen CU-500-Rates-of-Pay (Corrections Meet and Confer Employees) (Repealed)
310.TABLE W	Frozen RC-062-Rates-of-Pay (Technical Employees, AFSCME) (Repealed)
310.TABLE X	Frozen RC-063-Rates-of-Pay (Professional Employees, AFSCME) (Repealed)
310.TABLE Y	Frozen RC-063-Rates-of-Pay (Educators and Educator Trainees, AFSCME) (Repealed)
310.TABLE Z	Frozen RC-063-Rates-of-Pay (Physicians, AFSCME) (Repealed)
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) (Repealed)
310.TABLE AE	Frozen RC-090-Rates-of-Pay (Internal Security Investigators, Metropolitan Alliance of Police Chapter 294) (Repealed)
310.APPENDIX C	Comparison of Pay Grades or Salary Ranges Assigned to Classifications
310.ILLUSTRATION A	Classification Comparison Flow Chart: Both Classes are Whole
310.ILLUSTRATION B	Classification Comparison Flow Chart: One Class is Whole and One is Divided
310.ILLUSTRATION C	Classification Comparison Flow Chart: Both Classes are Divided
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,

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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 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.

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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 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,

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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, 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,

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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, 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

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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 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; preemptory 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; preemptory 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; preemptory 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; preemptory amendment at 27 Ill. Reg. 17433, effective November 7, 2003; amended at 27 Ill. Reg. 18560, effective December 1, 2003; preemptory 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; preemptory amendment at 28 Ill. Reg. 7323, effective May 10, 2004; amended at 28 Ill. Reg. 8842, effective June 11, 2004; preemptory amendment at 28 Ill. Reg. 9717, effective June 28, 2004; amended at 28 Ill. Reg. 12585, effective August 27, 2004; preemptory amendment at 28 Ill. Reg. 13011, effective September 8, 2004; preemptory amendment at 28 Ill. Reg. 13247, effective September 20, 2004; preemptory amendment at 28 Ill. Reg. 13656, effective September

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27, 2004; emergency amendment at 28 Ill. Reg. 14174, effective October 15, 2004, for a maximum of 150 days; emergency expired March 13, 2005; preemptory amendment at 28 Ill. Reg. 14689, effective October 22, 2004; preemptory amendment at 28 Ill. Reg. 15336, effective November 15, 2004; preemptory amendment at 28 Ill. Reg. 16513, effective December 9, 2004; preemptory amendment at 29 Ill. Reg. 726, effective December 15, 2004; amended at 29 Ill. Reg. 1166, effective January 7, 2005; preemptory amendment at 29 Ill. Reg. 1385, effective January 4, 2005; preemptory amendment at 29 Ill. Reg. 1559, effective January 11, 2005; preemptory amendment at 29 Ill. Reg. 2050, effective January 19, 2005; preemptory amendment at 29 Ill. Reg. 4125, effective February 23, 2005; amended at 29 Ill. Reg. 5375, effective April 4, 2005; preemptory amendment at 29 Ill. Reg. 6105, effective April 14, 2005; preemptory amendment at 29 Ill. Reg. 7217, effective May 6, 2005; preemptory amendment at 29 Ill. Reg. 7840, effective May 10, 2005; amended at 29 Ill. Reg. 8110, effective May 23, 2005; preemptory amendment at 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,

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effective January 17, 2007; peremptory amendment at 31 Ill. Reg. 4445, effective February 28, 2007; amended at 31 Ill. Reg. 4982, effective March 15, 2007; peremptory 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; peremptory amendment at 31 Ill. Reg. 10496, effective July 6, 2007; peremptory 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; peremptory amendment at 31 Ill. Reg. 13357, effective August 29, 2007; amended at 31 Ill. Reg. 13981, effective September 21, 2007; peremptory 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; peremptory amendment at 32 Ill. Reg. 598, effective December 27, 2007; amended at 32 Ill. Reg. 1082, effective January 11, 2008; peremptory amendment at 32 Ill. Reg. 3095, effective February 13, 2008; peremptory amendment at 32 Ill. Reg. 6097, effective March 25, 2008; peremptory amendment at 32 Ill. Reg. 7154, effective April 17, 2008; expedited correction at 32 Ill. Reg. 9747, effective April 17, 2008; peremptory amendment at 32 Ill. Reg. 9360, effective June 13, 2008; amended at 32 Ill. Reg. 9881, effective July 1, 2008; peremptory amendment at 32 Ill. Reg. 12065, effective July 9, 2008; peremptory amendment at 32 Ill. Reg. 13861, effective August 8, 2008; peremptory amendment at 32 Ill. Reg. 16591, effective September 24, 2008; peremptory amendment at 32 Ill. Reg. 16872, effective October 3, 2008; peremptory amendment at 32 Ill. Reg. 18324, effective November 14, 2008; peremptory amendment at 33 Ill. Reg. 98, effective December 19, 2008; amended at 33 Ill. Reg. 2148, effective January 26, 2009; peremptory amendment at 33 Ill. Reg. 3530, effective February 6, 2009; peremptory amendment at 33 Ill. Reg. 4202, effective February 26, 2009; peremptory amendment at 33 Ill. Reg. 5501, effective March 25, 2009; peremptory amendment at 33 Ill. Reg. 6354, effective April 15, 2009; peremptory amendment at 33 Ill. Reg. 6724, effective May 1, 2009; peremptory 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; peremptory amendment at 33 Ill. Reg. 10823, effective July 2, 2009; peremptory amendment at 33 Ill. Reg. 11082, effective July 10, 2009; peremptory amendment at 33 Ill. Reg. 11698, effective July 23, 2009; peremptory amendment at 33 Ill. Reg. 11895, effective July 31, 2009; peremptory amendment at 33 Ill. Reg. 12872, effective September 3, 2009; amended at 33 Ill. Reg. 14944, effective October 26, 2009; peremptory amendment at 33 Ill. Reg. 16598, effective November 13, 2009; peremptory 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; peremptory amendment at 34 Ill. Reg. 1425, effective January 5, 2010; peremptory amendment at 34 Ill. Reg. 3684, effective March 5, 2010; peremptory amendment at 34 Ill. Reg. 5776, effective April 2, 2010; peremptory amendment at

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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 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

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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; emergency amendment at 37 Ill. Reg. 11395, effective July 1, 2013, for a maximum of 150 days; preemptory amendment at 37 Ill. Reg. 11524, effective July 3, 2013; preemptory amendment at 37 Ill. Reg. 12588, effective July 19, 2013; preemptory amendment at 37 Ill. Reg. 13762, effective August 8, 2013; preemptory amendment at 37 Ill. Reg. 14219, effective August 23, 2013; amended at 37 Ill. Reg. 16925, effective October 8, 2013; preemptory amendment at 37 Ill. Reg. 17164, effective October 18, 2013; preemptory amendment at 37 Ill. Reg. 20410, effective December 6, 2013; preemptory amendment at 38 Ill. Reg. 2974, effective January 9, 2014; amended at 38 Ill. Reg. 5250, effective February 4, 2014; preemptory amendment at 38 Ill. Reg. 6725, effective March 6, 2014; emergency amendment at 38 Ill. Reg. 9080, effective April 11, 2014, for a maximum of 150 days; preemptory amendment at 38 Ill. Reg. 9136, effective April 11, 2014; amended at 38 Ill. Reg. 9207, effective April 21, 2014; preemptory amendment at 38 Ill. Reg. 13416, effective June 11, 2014; amended at 38 Ill. Reg. 14818, effective July 1, 2014.

SUBPART A: NARRATIVE

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)].

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"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 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 19, 2014~~February 21,~~

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~~2013~~ are:

Title	Title Code
Apparel/Dry Goods Specialist III	01233
Bridge Mechanic	05310
Bridge Tender	05320
Civil Engineer I	07601
Civil Engineer II	07602
Civil Engineer III	07603
Clinical Laboratory Associate	08200
Clinical Laboratory Technician I	08215
Clinical Laboratory Technician II	08216
Educator	13100
Educator Aide	13130
Engineering Technician II	13732
Engineering Technician III	13733
<u>Engineering Technician IV</u>	<u>13734</u>
<u>Heavy Construction Equipment Operator</u>	<u>18465</u>
Highway Maintainer	18639
Highway Maintenance Lead Worker	18659
Housekeeper II	19602
<u>Internal Security Investigator I</u>	<u>21731</u>
<u>Internal Security Investigator II</u>	<u>21732</u>
Labor Maintenance Lead Worker	22809
Laboratory Assistant	22995
Laboratory Associate I	22997
Laboratory Associate II	22998
Laborer (Maintenance)	23080
Licensed Practical Nurse I	23551
Licensed Practical Nurse II	23552
Maintenance Equipment Operator	25020
Maintenance Worker	25500
Pest Control Operator	31810
Power Shovel Operator (Maintenance)	33360
Property and Supply Clerk II	34792
Property and Supply Clerk III	34793
Public Service Administrator	37015
Senior Public Service Administrator	40070

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Silk Screen Operator	41020
Social Service Aide Trainee	41285
Storekeeper I	43051
Storekeeper II	43052
Storekeeper III	43053
Stores Clerk	43060

"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".

"In-hire Rate" – An in-hire rate is a minimum rate/step for a class that is above or below the normal minimum of the range or full scale rate, as approved by the Director of Central Management Services after a review of competitive market starting rates for similar classes or as negotiated between the Director of Central Management Services and a bargaining unit.

"Midpoint Salary" – The rate of pay that is the maximum rate and the minimum rate in the salary range added together divided by two and rounded up or down to the nearest whole dollar.

"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

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- 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~~
- 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

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- 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
- ~~9F = 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
- 2A = Revenue Audit Field Manager
- 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
- 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

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- 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
- 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

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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
- 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

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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.)

"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 38 Ill. Reg. 14818, effective July 1, 2014)

Section 310.100 Other Pay Provisions

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- a) Transfer – Upon the assignment of an employee to a vacant position in a class with the same pay grade as the class for the position being vacated, the employee's base salary will not be changed. Upon separation from a position in a given class and subsequent appointment to a position in the same pay grade, no increase in salary will be given.
- b) Entrance Base Salary –
 - 1) Qualifications Only Meet Minimum Requirements – When a candidate only meets the minimum requirements of the class specification upon entry to State service, an employee's entrance base salary is the in-hire rate or the minimum base salary of the pay grade.
 - 2) Qualifications Above Minimum Requirements – If a candidate possesses directly-related education and experience in excess of the minimum requirements of the class specification, the employing agency may offer the candidate an entrance base salary that is not more than 5% above the candidate's current base salary. Any deviation from the 5% maximum is a special salary adjustment (see Section 310.80(e)).
 - 3) Area Differential – For positions where additional compensation is required because of dissimilar economic or other conditions in the geographical area in which the positions are established, a higher entrance step may be authorized by the Director of Central Management Services. Present employees receiving less than the new rate shall be advanced to the new rate.
- c) Geographical Transfer – Upon geographical transfer from or to an area for which additional compensation has been authorized, an employee will receive an adjustment to the appropriate salary level for the new geographical area of assignment effective the first day of the month following date of approval.
- d) Differential and Overtime Pay – An eligible employee may have an amount added to the employee's base salary for a given pay period for work performed in excess of the normal requirements for the position and work schedule, as follows:
 - 1) Shift Differential Pay –

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- A) When Contract Contains No Provision – The contracts without a shift differential pay provision are for the RC-056, RC-090, RC-184 and VR-706 bargaining units. An employee may be paid an amount in addition to the employee's base salary for work performed on a regularly scheduled second or third shift. The additional compensation will be at a rate and in a manner approved by the Department of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstances.
- B) When Contract Contains a Provision – The shift differential pay provision in a contract is located in the Note in the Appendix A Table that exists for the specific bargaining unit. The Appendix A Tables with a shift differential pay provision are D (HR-001), E (RC-020), F (RC-019), G (RC-045), H (RC-006), I (RC-009), J (RC-014), K (RC-023), N (RC-010), O (RC-028), P (RC-029), Q (RC-033), R (RC-042), S (VR-704), V (CU-500), W (RC-062), X (RC-063), Y (RC-063), Z (RC-063) and AA (NR-916).
- 2) Overtime Pay –
- A) Eligibility – The Director of Central Management Services will maintain a list of titles and their overtime eligibility as determined by labor contracts, Federal Fair Labor Standards Act, or State law or regulations. Overtime shall be paid in accordance with the labor contracts, Federal Fair Labor Standards Act, and State law or regulations.
- B) Compensatory Time –
- i) When Contract Contains No Provision – Employees who are eligible for compensatory time may request such time, which may be granted by the agency at its discretion, considering, among other things, its operating needs.

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Compensatory time shall be taken within the fiscal year it was earned at a time convenient to the employee and consistent with the operating needs of the agency.

Compensatory time shall be accrued at the rate in which it is earned (straight time or time and a half), but shall not exceed 120 hours in any fiscal year. Compensatory time approved for non-union employees will be earned after 40 actual work hours in a workweek. Compensatory time not used by the end of the fiscal year in which it was earned shall be liquidated and paid in cash at the rate it was earned. Time spent in travel outside the normal work schedule shall not be accrued as compensatory time except as provided by labor contracts and the Federal Fair Labor Standards Act. At no time are overtime hours or compensatory time to be transferred from one agency to another agency.

- ii) When Represented by AFSCME (excludes CU-500) – If evidence demonstrates that circumstances prevented an employee from receiving a rest period or resulted in a rest period being interrupted, and no alternative time is authorized, the employee shall be entitled to compensatory time. For employees represented by RC-006, RC-009, RC-014, RC-028 and RC-042 bargaining units, accrued compensatory time not used by the end of the fiscal year in which it was earned shall be liquidated and paid in cash at the rate it was earned. Notwithstanding the above, employees who schedule compensatory time off by June 1st of the fiscal year shall be allowed to use such time through August 1st of the following fiscal year. Employees who earn compensatory time after June 1st shall be allowed to use such compensatory time through August 15th of the subsequent fiscal year.
- 3) Incentive Pay – An employee may be paid an amount in addition to the employee's base salary for work performed in excess of the normal work standard as determined by agency management. The additional compensation shall be at a wage rate and in a manner approved by the

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Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstances.

- 4) Temporary Assignment Pay –
 - A) When Assigned to a Higher-Level Position Classification –
 - i) When Contract Contains No Provision – A bargaining unit employee may be temporarily assigned to a bargaining unit position in a position classification having a higher pay grade and shall be eligible for temporary assignment pay. To be eligible for temporary assignment pay, the employee must be directed to perform the duties that distinguish the higher-level position classification and be held accountable for the responsibility of the higher classification. Employees shall not receive temporary assignment pay for paid days off except if the employee is given the assignment for 30 continuous days or more, the days off fall within the period of time and the employee works 75% of the time of the temporary assignment. Temporary assignment pay shall be calculated as if the employee received a promotion (see Section 310.80(d)(1)) into the higher pay grade. In no event is the temporary assignment pay to be lower than the minimum rate of the higher pay grade or greater than the maximum rate of the higher pay grade.
 - ii) When Represented by AFSCME (excludes CU-500) – If the employee who has been temporarily assigned is selected for the posted vacancy, the employee shall have the employee's his/her creditable service date adjusted to reflect the first date on which the employee was temporarily assigned without interruption. The uninterrupted time in a temporary assignment shall be credited in determining semi-automatic promotions, if the

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employee successfully performed the duty or duties which distinguish the position to which the employee has been temporarily assigned. When an employee in a position allocated to the Public Service Administrator title represented by an AFSCME (excludes CU-500) bargaining unit is temporarily assigned to a non-bargaining unit position, the time frames shall not exceed nine 9-months, unless mutually agreed otherwise. For other titles, the time limits for temporarily filling a position classification are in terms of work days or calendar months. The time limit herein may be extended by mutual agreement of the parties. The time limits are: While the Employer posts and fills a job vacancy for a period of 60 days from the date of posting; While an absent regular incumbent is utilizing sick leave, or accumulated time (vacation, holidays, personal days); Up to 30 work days in a six calendar month period while a regular incumbent is on disciplinary suspension or layoff; While a regular incumbent is attending required training classes; Up to six months while a regular incumbent is on any illness or injury, Union or jury leave of absence. Extension shall not be unreasonably denied; and Up to 60 work days in a 12 month period for other leaves, or where there is temporary change in work load, or other reasonable work related circumstances. Extension shall not be unreasonably denied.

- B) When Required to Use Second Language Ability – Employees who are bilingual or have the ability to use sign language, Braille, or another second language (e.g., Spanish) and whose job descriptions do not require that they do so shall be paid temporary assignment pay when required to perform duties requiring the ability. The temporary assignment pay received is prorated based on 5% or \$100 per month, whichever is greater, in addition to the employee's base rate.
- C) When Required to Apply Chemical Manually and represented by Teamsters RC-019 – Employees represented by RC-019 and appointed to the Highway Maintainer title who are required to

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perform duties of manual chemical application which require proper certification in chemical spraying shall receive \$1.00 an hour over their base pay during the time they are applying the chemical.

- 5) Travel for Required Training –
- A) When Represented by American Federation of State, County and Municipal Employees (AFSCME) (excludes CU-500) – When an employee is in a position represented by an AFSCME (excludes CU-500) bargaining unit, overtime shall be paid to the employee required to travel for training, orientation, or professional development when travel is in excess of the employee's normal commute and outside the employee's normal work hours. Where current practice exists, the employee who is paid overtime for travel during the employee's normal commute time outside normal work time, the practice shall continue.
 - B) When represented by Illinois Federation of Public Employees (IFPE) RC-029 – When an employee is in a position represented by IFPE RC-029 and in the Department of Agriculture, time spent traveling from an employee's residence to and/or from a work site in Cook, Will, Lake, DuPage, McHenry and Kane counties is not considered work time except where an employee is required to travel in excess of 20 miles one way or 25 minutes as measured from the employee's official headquarters in which case the miles in excess of 20 miles or minutes in excess of 25 minutes will be considered work time. The workday shall commence at the time of the pre-trip inspection for employees assigned to drive vehicles, which require a commercial driver's license.
- e) Out-of-State Assignment – Employees who are assigned to work out-of-state on a temporary basis may receive an appropriate differential during the period of the assignment, as approved by the Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstances.

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- f) Equivalent Earned Time – Employees shall retain their equivalent earned time upon their positions' representation by an American Federation of State, County and Municipal Employees bargaining unit. The use of the equivalent earned time is approved by supervisors, prior to other benefit time excluding sick and personal business leave, in increments of 15 minutes after the initial use of one-half hour, and granted under the same criteria as vacation time. Employees may substitute equivalent earned time for sick leave in accordance to sick leave policies and procedures.
- g) Part-Time Work – Part-time employees whose base salary is other than an hourly or daily basis shall be paid on a daily basis computed by dividing the annual rate of salary by the total number of work days in the year.
- h) Lump Sum Payment – Lump sum payment shall be provided for accrued vacation, sick leave and unused compensatory overtime at the current base rate to those employees separated from employment under the Personnel Code. Leaves of absence and temporary layoff (per 80 Ill. Adm. Code 302.510) are not separations and therefore lump sum cannot be given in these transactions. Method of computation is explained in Section 310.70(a).

AGENCY NOTE – The method to be used in computing the lump sum payment for accrued vacation, sick leave and unused compensatory overtime payment for an incumbent entitled to shift differential during the employee's regular work hours will be to use the employee's current base salary plus the shift differential pay. Sick leave earned prior to January 1, 1984 and after December 31, 1997 is not compensable. Sick leave earned and not used between January 1, 1984 and December 31, 1997 will be compensable at the current base daily rate times one-half of the total number of compensable sick days.

- i) Salary Treatment Upon Return From Leave –
- 1) An employee returning from Military Leave (80 Ill. Adm. Code 302.220 and 303.170), Peace Corps Leave (80 Ill. Adm. Code 302.230), Service-Connected Disability Leave (80 Ill. Adm. Code 303.135), Educational Leave (80 Ill. Adm. Code 302.215), Disaster Service Leave with Pay (80 Ill. Adm. Code 303.175), Family Responsibility Leave (80 Ill. Adm. Code 303.148), Leave to accept a temporary, emergency, provisional, exempt

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(80 Ill. Adm. Code 303.155) or trainee position, Leave to serve in domestic peace or job corps (80 Ill. Adm. Code 302.230) or leave to serve in an interim assignment will be placed on the step that reflects satisfactory performance increases to which the employee would have been entitled during the employee's period of leave. Creditable service date will be maintained.

- 2) An employee returning to the employee's former pay grade from any other leave (not mentioned in subsection (j)(1)) of over 14 days will be placed at the step on which the employee was situated prior to the employee's leave, and the employee's creditable service date will be extended by the duration of the leave.

j) Salary Treatment Upon Reemployment –

- 1) Upon the reemployment of an employee in a class with the same pay grade as the class for the position held before layoff, the employee will be placed at the same salary step as held at the time of the layoff, and the employee's creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.
- 2) Upon the reemployment of an employee in a class at a lower salary range than the range of the class for the position held before layoff, the employee will be placed at the step in the lower pay grade that provides the base salary nearest in amount to, but less than, the current value of the step held at the time of layoff, and the employee's creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.

- k) Reinstatement – The salary upon reinstatement should not provide more than a 5% increase over the candidate's current base salary or exceed the current value of the salary step held in the position where previously certified without prior approval by the Director of Central Management Services. In no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the pay grade. Any deviation from the 5% maximum, except when the resulting salary is the minimum rate of the pay grade, is a special salary adjustment (see Section 310.80(e)).

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- l) Longevity Pay –
- 1) When Contract Contains No Provision – The contracts without a longevity pay provision are for the HR-001, RC-019, RC-020, RC-090 and RC-184 bargaining units. The Step 8 rate shall be increased by \$25 per month for those employees who have attained 10 years of service and have three years of creditable service on Step 8 in the same pay grade. The Step 8 rate shall be increased by \$50 per month for those employees who have attained 15 years of service and have three years of creditable service on Step 8 in the same pay grade.
 - 2) When Contract Contains a Provision – The longevity pay provision in a contract is located in the Note in the Appendix A Table that exists for the specific bargaining unit. The Appendix A Tables with a longevity pay provision are [A \(RC-104\)](#), B (VR-706), C (RC-056), G (RC-045), H (RC-006), I (RC-009), J (RC-014), K (RC-023), N (RC-010), O (RC-028), P (RC-029), Q (RC-033), R (RC-042), S (VR-704), V (CU-500), W (RC-062), X (RC-063), Y (RC-063), Z (RC-063), AA (NR-916) and AC (RC-036).
- m) Bilingual Pay – Individual positions whose job descriptions require the use of sign language, Braille, or another second language (e.g., Spanish) shall receive 5% or \$100 per month, whichever is greater, in addition to the employee's base rate.
- n) Maximum Security Rates – An employee represented by an AFSCME (excludes CU-500) bargaining unit with seven or more years of continuous service with the Departments of Corrections and Juvenile Justice who is currently employed at Department of Corrections or Juvenile Justice maximum security institution shall be placed on the maximum security schedule as long as they remain an employee at a maximum security facility. Maximum Security rates are denoted by Pay Plan Codes P and S (defined in Section 310.50).

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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

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Schedule (Appendix D), and Broad-Band Pay Range Classes Salary Schedule (Appendix G) shall be effective for Fiscal Year ~~2015~~2014.

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

SUBPART B: SCHEDULE OF RATES

Section 310.260 Trainee Rate

Rates of pay for employees working in classes pursuant to a Trainee Program (80 Ill. Adm. Code 302.170) shall conform to those set forth in negotiated pay grades within Negotiated Rates of Pay (Appendix A) unless the rate is red-circled (Section 310.220(e)) or salary ranges within the Merit Compensation System Salary Schedule (Appendix D). The process of assigning merit compensation salary ranges to Trainee Program classifications is in Section 310.415. The Trainee Program classifications are:

Title	Title Code	Negotiated Pay Grade	Merit Compensation Salary Range
Account Technician Trainee	00118	None	MS-04
Accounting and Fiscal Administration Career Trainee	00140	RC-062-12	MS-09
Actuarial Examiner Trainee	00196	RC-062-13	MS-10
Administrative Services Worker Trainee	00600	RC-014-02	MS-02
Animal and Animal Products Investigator Trainee	01075	None	MS-09
Appraisal Specialist Trainee	01255	None	MS-09
Arson Investigations Trainee	01485	None	MS-12
Behavioral Analyst Associate	04355	RC-062-15	MS-12
Child Support Specialist Trainee	07200	RC-062-12	MS-09
Children and Family Service Intern, Option 1	07241	RC-062-12	MS-09
Children and Family Service Intern, Option 2	07242	RC-062-15	MS-12
Civil Engineer Trainee	07607	NR-916	MS-15

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Clerical Trainee	08050	RC-014-TR	MS-01
Clinical Laboratory Technologist Trainee	08229	RC-062-14	MS-11
Clinical Psychology Associate	08255	RC-063-18	MS-19
Commerce Commission Police Officer Trainee	08455	None	MS-10
Conservation Police Officer Trainee	09345	RC-110	MS-06
Correctional Officer Trainee	09676	RC-006-05	MS-08
<u>Corrections Nurse Trainee</u>	<u>09838</u>	<u>Pending Negotiations</u>	<u>MS-16</u>
Criminal Justice Specialist Trainee	10236	RC-062-13	MS-10
Data Processing Operator Trainee	11428	RC-014-02	MS-02
Data Processing Technician Trainee	11443	RC-028-06	MS-04
Disability Claims Adjudicator Trainee	12539	RC-062-13	MS-10
Economic Development Representative Trainee	12939	None	MS-10
Energy and Natural Resources Specialist Trainee	13715	RC-062-12	MS-09
Financial Institutions Examiner Trainee	14978	RC-062-13	MS-10
Fingerprint Technician Trainee	15209	None	MS-05
<u>Firearms Eligibility Analyst Trainee</u>	<u>15375</u>	<u>Pending Negotiations</u>	
Fire Prevention Inspector Trainee	15320	RC-029-12	MS-10
Forensic Scientist Trainee	15897	RC-062-15	MS-12
Gaming Special Agent Trainee	17195	RC-062-14	MS-11
Geographic Information Trainee	17276	RC-063-15	MS-12
Governmental Career Trainee	17325	None	MS-09
Graduate Pharmacist	17345	RC-063-20	MS-23
Hearing and Speech Associate	18231	RC-063-18	MS-19

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Human Resources Trainee	19694	RC-014-07	MS-04
Human Services Grants Coordinator Trainee	19796	RC-062-12	MS-09
Industrial Services Consultant Trainee	21125	RC-062-11	MS-08
Industrial Services Hygienist Trainee	21133	RC-062-12	MS-09
Information Services Intern	21160	RC-063-15	MS-12
Insurance Analyst Trainee	21566	RC-014-07	MS-04
Insurance Company Financial Examiner Trainee	21610	RC-062-13	MS-10
Internal Auditor Trainee	21726	None	MS-09
Juvenile Justice Specialist Intern	21976	RC-006-11	MS-13
Liability Claims Adjuster Trainee	23375	None	MS-09
Life Sciences Career Trainee	23600	RC-062-12	MS-09
Management Operations Analyst Trainee	25545	None	MS-12
Manpower Planner Trainee	25597	RC-062-12	MS-09
Meat and Poultry Inspector Trainee	26075	RC-033	MS-07
Mental Health Administrator Trainee	26817	RC-062-16	MS-12
Mental Health Specialist Trainee	26928	RC-062-11	MS-08
Mental Health Technician Trainee	27020	RC-009-01	MS-03
Methods and Procedures Career Associate Trainee	27137	RC-062-09	MS-06
Office Occupations Trainee	30075	None	MS-01
Police Officer Trainee	32985	None	MS-06
Polygraph Examiner Trainee	33005	None	MS-12
Products and Standards Inspector Trainee	34605	None	MS-09
Program Integrity Auditor Trainee	34635	RC-062-12	MS-09
Psychologist Associate	35626	RC-063-15	MS-12

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Psychology Intern	35660	None	MS-15
Public Administration Intern	35700	None	MS-11
Public Aid Investigator Trainee	35874	RC-062-14	MS-11
Public Health Program Specialist Trainee	36615	RC-062-12	MS-09
Public Safety Inspector Trainee	37010	RC-062-10	MS-07
Public Service Trainee	37025	None	MS-01
Rehabilitation Counselor Trainee	38159	RC-062-15	MS-12
Rehabilitation/Mobility Instructor Trainee	38167	RC-063-15	MS-12
Research Fellow, Option B	38211	None	MS-19
Resident Physician	38270	None	MS-15
Residential Care Worker Trainee	38279	RC-009-11	MS-05
Revenue Auditor Trainee (IL)	38375	RC-062-12	MS-09
Revenue Auditor Trainee (states other than IL and not assigned to RC-062-15)	38375	RC-062-13	MS-09
Revenue Auditor Trainee (see Note in Appendix A Table W)	38375	RC-062-15	MS-09
Revenue Collection Officer Trainee	38405	RC-062-12	MS-09
Revenue Special Agent Trainee	38565	RC-062-14	MS-11
Revenue Tax Specialist Trainee	38575	RC-062-10	MS-07
Security Therapy Aide Trainee	39905	RC-009-13	MS-06
Seed Analyst Trainee	39953	None	MS-07
Social Service Aide Trainee	41285	RC-006-01 RC-009-02	MS-03
Social Services Career Trainee	41320	RC-062-12	MS-09
Social Worker Intern	41430	None	MS-15
Student Intern	43190	None	MS-01

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Student Worker	43200	None	MS-01
Telecommunications Systems Technician Trainee	45314	None	MS-05
Telecommunicator Trainee	45325	RC-014-10	MS-07
Terrorism Research Specialist Trainee	45375	RC-062-14	MS-11
Weatherization Specialist Trainee	49105	RC-062-12	MS-09

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

SUBPART C: MERIT COMPENSATION SYSTEM

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.

"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.

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"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.

"In-hire Rate" – An in-hire rate is a minimum rate/step for a class that is above or below the normal minimum of the range or full scale rate, as approved by the Director of Central Management Services after a review of competitive market starting rates for similar classes or as negotiated between the Director of Central Management Services and a bargaining unit.

"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

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		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

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
<u>2A</u>	≡	<u>Revenue Audit Field Manager</u>
2B	=	Financial Regulatory
3	=	Management Information System/Data Processing/Telecommunications
4	=	Physical Sciences/Environment
5	=	Agriculture/Conservation
6	=	Health and Human Services

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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
 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

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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

"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.

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

"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 38 Ill. Reg. 14818, effective July 1, 2014)

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Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE A RC-104 (Conservation Police Supervisors, Illinois Fraternal Order of Police Labor Council)**

<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	09339	RC-104	Q
Senior Public Service Administrator, Option 7 (captain function) Department of Natural Resources (<u>through October 6, 2013</u>)	40070	RC-104	Q

NOTES

NOTE: In-Hire Rate – Effective February 14, 2014, a new employee shall be hired at 33% of the differential between a Conservation Police Officer II and the employee's new rank at the appropriate longevity level. Upon successful completion of 18 month of service, the employee shall be paid 66% of the rank differential between a Conservation Police Officer II and the employee's new rank at the appropriate longevity level. Upon successful completion of 36 month of service, the employee shall be paid 100% of the rank differential between a Conservation Police Officer II and the employee's new rank at the appropriate longevity level.

Longevity Bonus – Employees shall receive longevity bonus at the beginning of the 9, 10, 12.5, 14, 15, 17.5, 20, 21, 22.5 and 25 years of service.

Option Clarification – The positions allocated to the Senior Public Service Administrator title that ~~were~~ assigned to the negotiated RC-104 rates through October 6, 2013 had have the Option 7. See the definition of option in Section 310.50.

Supervisory Enhancement – Effective January 1, 2014, Conservation Police Sergeants with 15 or more years of service receive to their rate of pay a onetime adjustment increase, which is 7.9% above the rate of pay of the Conservation Police Officer II with the same years of service. The Agreement's Appendix A – Wages chart calculation assumes that the Conservation Police Officer II title receives the same general increase as the Conservation Police Sergeants. Effective January 1, 2014, Conservation Police

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Lieutenants' rate of pay shall reflect an amount 3.9% greater than Sergeants with the same steps or years of service.

Effective July 1, 2012

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	10	12.5	14	15	17.5	20	21	22.5	25
	Yrs	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

Effective July 1, 2013

Title	S T E P S						
	1	2	3	4	5	6	7
Conservation Police Sergeant	5488	5769	6047	6329	6623	6933	6933
Conservation Police Lieutenant	5651	5939	6225	6517	6818	7138	7138

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NOTICE OF ADOPTED AMENDMENTS

Senior Public Service

Administrator, Option 7

(captain function) Department
of Natural Resources

5933 6237 6538 6841 7158 7493 7493

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	7255	7673	7863	7863	8233	8619	9037	3121	9549	10001
Conservation Police Lieutenant	7468	7901	8092	8092	8475	8873	9299	9389	9830	10294
Senior Public Service Administrator, Option 7 (captain function) Department of Natural Resources	7841	8296	8497	8497	8898	9316	9767	9857	10321	10810

Effective October 7, 2013

<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>
<u>Conservation Police Sergeant</u>	<u>5488</u>	<u>5769</u>	<u>6047</u>	<u>6329</u>	<u>6623</u>	<u>6933</u>	<u>6933</u>
<u>Conservation Police Lieutenant</u>	<u>5651</u>	<u>5939</u>	<u>6225</u>	<u>6517</u>	<u>6818</u>	<u>7138</u>	<u>7138</u>

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>
<u>Conservation Police Sergeant</u>	<u>7255</u>	<u>7673</u>	<u>7863</u>	<u>7863</u>	<u>8233</u>	<u>8619</u>	<u>9037</u>	<u>3121</u>	<u>9549</u>	<u>10001</u>

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Conservation
Police
Lieutenant7468 7901 8092 8092 8475 8873 9299 9389 9830 10294**Effective January 1, 2014**

Title	S T E P S						
	1	2	3	4	5	6	7
Conservation Police Sergeant	5488	5769	6047	6329	6623	6933	7094
Conservation Police Lieutenant	5702	5994	6283	6576	6881	7203	7371

Longevity Bonus Rates

Title	9	10	12.5	14	15	17.5	20	21	22.5	25
	Yrs	Yrs								
Conservation Police Sergeant	7255	7673	7863	8098	8333	8719	9134	9221	9648	10096
Conservation Police Lieutenant	7538	7972	8170	8414	8658	9059	9490	9581	10024	10490

Effective July 1, 2014

Title	S T E P S						
	1	2	3	4	5	6	7
Conservation Police Sergeant	5598	5884	6168	6456	6755	7072	7236
Conservation Police Lieutenant	5816	6114	6409	6708	7019	7347	7518

Longevity Bonus Rates

Title	9	10	12.5	14	15	17.5	20	21	22.5	25
	Yrs	Yrs								
Conservation Police Sergeant	7400	7826	8020	8260	8500	8893	9317	9405	9841	10298
Conservation Police Lieutenant	7689	8131	8333	8582	8831	9240	9680	9773	10224	10700

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(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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Section 310.APPENDIX A Negotiated Rates of Pay

Section 310.TABLE B VR-706 (Assistant Automotive Shop Supervisors, Automotive Shop Supervisors and Meat and Poultry Inspector Supervisors, Laborers' – ISEA Local #2002)

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Plan Code</u>
Assistant Automotive Shop Supervisor	01565	VR-706	B
Automotive Shop Supervisor	03749	VR-706	B
Meat and Poultry Inspector Supervisor	26073	VR-706	B

NOTE: Longevity Pay – Effective July 1, 2013, an employee on Step 8, having 10 years of continuous service and three years creditable service at Step 8, shall be paid \$50 per month. An employee with 15 years continuous services and three years of creditable service at Step 8 shall receive \$75 per month.

Effective July 1, 2012

<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>	<u>8</u>
Assistant Automotive Shop Supervisor	4152	4275	4398	4522	4643	4768	4892	5016
Automotive Shop Supervisor	5112	5271	5432	5592	5754	5914	6075	6235
Meat and Poultry Inspector Supervisor	4389	4579	4762	4942	5133	5422	5531	5586

Effective April 1, 2013

<u>Title</u>	<u>STEPS</u>										
	<u>1e</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>
Assistant Automotive Shop Supervisor	3778	3903	4027	4152	4275	4398	4522	4643	4768	4892	5016
Automotive Shop Supervisor	4652	4805	4959	5112	5271	5432	5592	5754	5914	6075	6235
Meat and Poultry Inspector Supervisor	3994	4126	4257	4389	4579	4762	4942	5133	5422	5531	5586

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Effective July 1, 2013

<u>Title</u>	<u>STEPS</u>										
	<u>1e</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>
Assistant Automotive Shop Supervisor	3854	3981	4108	4235	4361	4486	4612	4736	4863	4990	5116
Automotive Shop Supervisor	4745	4901	5058	5214	5376	5541	5704	5869	6032	6197	6360
Meat and Poultry Inspector Supervisor	4074	4209	4342	4477	4671	4857	5041	5236	5530	5642	5698

Effective July 1, 2014

<u>Title</u>	<u>STEPS</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>
Assistant Automotive Shop Supervisor	3931	4061	4190	4320	4448	4576	4704	4831	4960	5090	5218
Automotive Shop Supervisor	4840	4999	5159	5318	5484	5652	5818	5986	6153	6321	6487
Meat and Poultry Inspector Supervisor	4155	4293	4429	4567	4764	4954	5142	5341	5641	5755	5812

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE C RC-056 (Site Superintendents and Departments of Veterans' Affairs, Natural Resources, Human Services and Agriculture and Historic Preservation Agency Managers, IFPE)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Agricultural Executive	00800	RC-056	20
Agricultural Land and Water Resources Supervisor	00811	RC-056	21
Natural Resources Education Program Coordinator	28834	RC-056	20
Natural Resources Grant Coordinator	28835	RC-056	19
Natural Resources Manager I	28836	RC-056	20
Natural Resources Manager II	28837	RC-056	22
Natural Resources Manager III	28838	RC-056	24
Natural Resources Site Manager I	28841	RC-056	20
Natural Resources Site Manager II	28842	RC-056	22
Plant and Pesticide Specialist Supervisor	32506	RC-056	19
Security Officer Chief (See Note)	39875	RC-056	16
Security Officer Lieutenant (See Note)	39876	RC-056	14
Site Superintendent I	41211	RC-056	19
Site Superintendent II	41212	RC-056	21
Site Superintendent III	41213	RC-056	23
Veterinary Consumer Safety Officer	47911	RC-056	19
Veterinary Pathologist	47916	RC-056	23
Veterinary Supervisor I	47917	RC-056	21
Veterinary Supervisor II	47918	RC-056	22
Warehouse Examiner Supervisor	48786	RC-056	19

NOTES: Pension Formula Change – 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

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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 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).

Longevity Pay – Effective July 1, 2010, the Step 8 rate shall be increased by \$25 per month for those employees who have been on Step 8 for one year. Effective July 1, 2011, those same employees shall have their Step 8 rate increased by \$50 per month. Effective July 1, 2011, the Step 8 rate shall be increased by \$50 per month for those employees not eligible for the longevity increases stated in this Note and have attained 10 years of continuous service and have three or more years creditable service at Step 8. Effective July 1, 2013, an employee on Step 8, having 10 years of continuous service and three years creditable service at Step 8, shall be paid \$75 per month. Effective July 1, 2013, an employee on Step 8, having 15 years of continuous service and three years creditable service at Step 8, shall be paid \$100 per month.

Effective July 1, 2012

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<u>8</u>
14	B	3879	4032	4207	4362	4527	4791	4886	5083
14	Q	4045	4209	4393	4557	4731	5007	5106	5312
16	B	4250	4438	4623	4816	5008	5303	5413	5630
16	Q	4438	4638	4830	5031	5235	5545	5769	6001
19	B	4968	5203	5444	5675	5911	6268	6390	6648
20	B	5248	5492	5754	6002	6251	6632	6762	7033
21	B	5546	5814	6084	6363	6629	7041	7183	7468
22	B	5867	6152	6445	6742	7023	7459	7609	7914
23	B	6228	6548	6859	7176	7486	7956	8114	8439
24	B	6427	6762	7085	7414	7742	8205	8391	8725

Effective May 1, 2013

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Pay Grade	Pay Plan Code	STEPS										
		1e	1b	1a	1	2	3	4	5	6	7	8
14	B	3530	3646	3763	3879	4032	4207	4362	4527	4791	4886	5083
14	Q	3681	3802	3924	4045	4209	4393	4557	4731	5007	5106	5312
16	B	3868	3995	4123	4250	4438	4623	4816	5008	5303	5413	5630
16	Q	4039	4172	4305	4438	4638	4830	5031	5235	5545	5769	6001
19	B	4521	4670	4819	4968	5203	5444	5675	5911	6268	6390	6648
20	B	4776	4933	5091	5248	5492	5754	6002	6251	6632	6762	7033
21	B	5047	5213	5380	5546	5814	6084	6363	6629	7041	7183	7468
22	B	5339	5515	5691	5867	6152	6445	6742	7023	7459	7609	7914
23	B	5667	5854	6041	6228	6548	6859	7176	7486	7956	8114	8439
24	B	5849	6041	6234	6427	6762	7085	7414	7742	8205	8391	8725

Effective July 1, 2013

Pay Grade	Pay Plan Code	STEPS										
		1e	1b	1a	1	2	3	4	5	6	7	8
14	B	3601	3719	3838	3957	4113	4291	4449	4618	4887	4984	5185
14	Q	3755	3878	4002	4126	4293	4481	4648	4826	5107	5208	5418
16	B	3945	4075	4205	4335	4527	4715	4912	5108	5409	5521	5743
16	Q	4120	4255	4391	4527	4731	4927	5132	5340	5656	5884	6121
19	B	4611	4763	4915	5067	5307	5553	5789	6029	6393	6518	6781
20	B	4872	5032	5193	5353	5602	5869	6122	6376	6765	6897	7174
21	B	5148	5317	5488	5657	5930	6206	6490	6762	7182	7327	7617
22	B	5446	5625	5805	5984	6275	6574	6877	7163	7608	7761	8072
23	B	5780	5971	6162	6353	6679	6996	7320	7636	8115	8276	8608
24	B	5966	6162	6359	6556	6897	7227	7562	7897	8369	8559	8900

Effective July 1, 2014

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Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
14	B	3673	3793	3915	4036	4195	4377	4538	4710	4985	5084	5289
14	Q	3830	3956	4082	4209	4379	4571	4741	4923	5209	5312	5526
16	B	4024	4157	4289	4422	4618	4809	5010	5210	5517	5631	5858
16	Q	4202	4340	4479	4618	4826	5026	5235	5447	5769	6002	6243
19	B	4703	4858	5013	5168	5413	5664	5905	6150	6521	6648	6917
20	B	4969	5133	5297	5460	5714	5986	6244	6504	6900	7035	7317
21	B	5251	5423	5598	5770	6049	6330	6620	6897	7326	7474	7769
22	B	5555	5738	5921	6104	6401	6705	7015	7306	7760	7916	8233
23	B	5896	6090	6285	6480	6813	7136	7466	7789	8277	8442	8780
24	B	6085	6285	6486	6687	7035	7372	7713	8055	8536	8730	9078

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay

Section 310.TABLE D HR-001 (Teamsters Local #700)

Title	Title Code	Bargaining Unit	Pay Plan Code	Full Scale Mo.	Effective Date
Highway Maintainer (Snowbirds)	18639	HR-001	Q	3664.00	January 1, 2010
Highway Maintainer (Snowbirds)	18639	HR-001	Q	3738.00	July 1, 2010
Highway Maintainer (Snowbirds)	18639	HR-001	Q	3850.00	January 1, 2011
Highway Maintainer (Snowbirds)	18639	HR-001	Q	3964.00	July 1, 2011
Highway Maintainer (Snowbirds)	18639	HR-001	Q	4083.00	January 1, 2012
Highway Maintainer (Snowbirds)	18639	HR-001	Q	4205.00	June 30, 2012

NOTE: Definition of Snowbirds – Snowbirds are all seasonal, full-time Highway Maintainers whose primary function is snow removal.

Effective July 1, 2012

Title	Title Code	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.								
Building Services Worker	05616	B											3781	21.73
Elevator Operator	13500	B											3859	22.18
Elevator Operator—Assistant Starter	13500	B											3909	22.47
Elevator Operator—Starter	13500	B											3933	22.60
Grounds Supervisor	17549	B											5729	32.93
Grounds Supervisor (DHS — Chicago Read)	17549	B											5937	34.12

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Building Services														
Worker	05616	B												3857 22.17
Elevator														
Operator	13500	B												3936 22.62
Elevator														
Operator— Assistant Starter	13500	B												3987 22.91
Elevator														
Operator— Starter	13500	B												4012 23.06
Grounds														
Supervisor	17549	B												5844 33.59
Grounds														
Supervisor (DHS= Chicago Read)	17549	B												6056 34.80
Grounds														
Supervisor (DHS= Supervisor Tractor-Trailer)	17549	B												6345 36.47
Heavy														
Construction Equipment Operator (Regular=RG)	18465	Q												6194 35.60
Heavy														
Construction Equipment Operator (Bridge Crew= BC)	18465	Q												6283 36.11
Highway														
Maintainer (Regular=RG)	18639	Q	4550	26.15	4853	27.89	5156	29.63	5459	31.37	5763	33.12	6066	34.86
Highway														
Maintainer (Bridge Crew= BC)	18639	Q	4619	26.55	4927	28.32	5235	30.09	5543	31.86	5851	33.63	6159	35.40
Highway														
Maintainer (Drill Rig= DR)	18639	Q	4646	26.70	4955	28.48	5265	30.26	5575	32.04	5884	33.82	6194	35.60
Highway														
Maintainer	18639	Q	4648	26.71	4958	28.49	5267	30.27	5577	32.05	5887	33.83	6197	35.61

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Emergency Patrol = EP)			
Highway Maintenance Lead Worker (Regular = RG)	18659	Q	6234 35.83
Highway Maintenance Lead Worker (Bridge Crew = BC)	18659	Q	6323 36.34
Highway Maintenance Lead Worker (Emergency Patrol = EP)	18659	Q	6362 36.56
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular = RG)	18659	Q	6297 36.19
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew = BC)	18659	Q	6386 36.70
Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol = EP)	18659	Q	6426 36.93
Laborer (Maintenance) (Regular = RG)	23080	B	5872 33.75
Maintenance Equipment Operator	25020	B	5990 34.43
Maintenance Equipment Operator (DHS)	25020	B	6020 34.60

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

=Tractor Trailer) Maintenance Equipment Operator (Dispatcher)	25020	B													6210	35.69
Maintenance Worker (not DOT, DHS= Chicago Read or DHS= Forensic)	25500	B													5804	33.36
Maintenance Worker (DHS =Chicago Read)	25500	B													5990	34.43
Maintenance Worker (DHS =Forensic)	25500	Q													6066	34.86
Maintenance Worker (DOT =Regular= RG)	25500	B													5920	34.02
Maintenance Worker (DOT =Emergency Patrol =EP)	25500	B													6046	34.75
Power Shovel Operator (Maintenance) (Regular =RG)	33360	B													6283	36.11

Effective July 24, 2013

<u>Title</u>	<u>Title Code</u>	<u>Pay Plan Code</u>	75%		80%		85%		90%		95%		Full Scale	
			<u>Mo.</u>	<u>Hr.</u>										
Building Services Worker	05616	B	2893	16.63	3086	17.74	3278	18.84	3471	19.95	3664	21.06	3857	22.17
Elevator Operator	13500	B	2952	16.97	3149	18.10	3346	19.23	3542	20.36	3739	21.49	3936	22.62
Elevator Operator—	13500	B	2990	17.18	3190	18.33	3389	19.48	3588	20.62	3788	21.77	3987	22.91

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Assistant Starter Elevator Operator— Starter	13500	B	3009	17.29	3210	18.45	3410	19.60	3611	20.75	3811	21.90	4012	23.06
Grounds Supervisor	17549	B	4383	25.19	4675	26.87	4967	28.55	5260	30.23	5552	31.91	5844	33.59
Grounds Supervisor (DHS— Chicago Read)	17549	B	4542	26.10	4845	27.84	5148	29.59	5450	31.32	5753	33.06	6056	34.80
Grounds Supervisor (DHS— Supervisor Tractor-Trailer)	17549	B	4759	27.35	5076	29.17	5393	30.99	5711	32.82	6028	34.64	6345	36.47
Heavy Construction Equipment Operator (Regular—RG)	18465	Q	4646	26.70	4955	28.48	5265	30.26	5575	32.04	5884	33.82	6194	35.60
Heavy Construction Equipment Operator (Bridge Crew— BC)	18465	Q	4712	27.08	5026	28.89	5341	30.70	5655	32.50	5969	34.30	6283	36.11
Highway Maintainer (Regular—RG)	18639	Q	4550	26.15	4853	27.89	5156	29.63	5459	31.37	5763	33.12	6066	34.86
Highway Maintainer (Bridge Crew— BC)	18639	Q	4619	26.55	4927	28.32	5235	30.09	5543	31.86	5851	33.63	6159	35.40
Highway Maintainer (Drill Rig— DR)	18639	Q	4646	26.70	4955	28.48	5265	30.26	5575	32.04	5884	33.82	6194	35.60
Highway Maintainer (Emergency Patrol—EP)	18639	Q	4648	26.71	4958	28.49	5267	30.27	5577	32.05	5887	33.83	6197	35.61
Highway Maintenance Lead Worker (Regular—RG)	18659	Q	4676	26.87	4987	28.66	5299	30.45	5611	32.25	5922	34.03	6234	35.83

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Highway Maintenance Lead Worker (Bridge Crew = BC)	18659	Q	4742	27.25	5058	29.07	5375	30.89	5691	32.71	6007	34.52	6323	36.34
Highway Maintenance Lead Worker (Emergency Patrol = EP)	18659	Q	4772	27.43	5090	29.25	5408	31.08	5726	32.91	6044	34.74	6362	36.56
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular = RG)	18659	Q	4723	27.14	5038	28.95	5352	30.76	5667	32.57	5982	34.38	6297	36.19
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew = BC)	18659	Q	4790	27.53	5109	29.36	5428	31.20	5747	33.03	6067	34.87	6386	36.70
Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol = EP)	18659	Q	4820	27.70	5141	29.55	5462	31.39	5783	33.24	6105	35.09	6426	36.93
Laborer (Maintenance) (Regular = RG)	23080	B	4404	25.31	4698	27.00	4991	28.68	5285	30.37	5578	32.06	5872	33.75
Maintenance Equipment Operator	25020	B	4493	25.82	4792	27.54	5092	29.26	5391	30.98	5691	32.71	5990	34.43
Maintenance Equipment Operator (DHS = Tractor Trailer)	25020	B	4515	25.95	4816	27.68	5117	29.41	5418	31.14	5719	32.87	6020	34.60
Maintenance Equipment Operator (Dispatcher)	25020	B	4658	26.77	4968	28.55	5279	30.34	5589	32.12	5900	33.91	6210	35.69

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Maintenance Worker (not DOT, DHS= Chicago Read or DHS= Forensic)	25500	B	4353	25.02	4643	26.68	4933	28.35	5224	30.02	5514	31.69	5804	33.36
Maintenance Worker (DHS =Chicago Read)	25500	B	4493	25.82	4792	27.54	5092	29.26	5391	30.98	5691	32.71	5990	34.43
Maintenance Worker (DHS =Forensic)	25500	Q	4550	26.15	4853	27.89	5156	29.63	5459	31.37	5763	33.12	6066	34.86
Maintenance Worker (DOT =Regular= RG)	25500	B	4440	25.52	4736	27.22	5032	28.92	5328	30.62	5624	32.32	5920	34.02
Maintenance Worker (DOT =Emergency Patrol=EP)	25500	B	4535	26.06	4837	27.80	5139	29.53	5441	31.27	5744	33.01	6046	34.75
Power Shovel Operator (Maintenance) (Regular=RG)	33360	B	4712	27.08	5026	28.89	5341	30.70	5655	32.50	5969	34.30	6283	36.11

Effective July 1, 2014

Title	Title Code	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.								
Building Services Worker	05616	B	2951	16.96	3148	18.09	3344	19.22	3540	20.34	3737	21.48	3934	22.61
Elevator Operator	13500	B	3011	17.30	3212	18.46	3413	19.61	3613	20.76	3814	21.92	4015	23.07
Elevator Operator - Assistant Starter	13500	B	3050	17.53	3254	18.70	3457	19.87	3660	21.03	3864	22.21	4067	23.37
Elevator Operator - Starter	13500	B	3069	17.64	3274	18.82	3478	19.99	3683	21.17	3887	22.34	4092	23.52
Grounds Supervisor	17549	B	4471	25.70	4769	27.41	5066	29.11	5365	30.83	5663	32.55	5961	34.26
Grounds Supervisor	17549	B	4633	26.63	4942	28.40	5251	30.18	5559	31.95	5868	33.72	6177	35.50

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(DHS – Chicago Read) Grounds Supervisor (DHS – Supervisor Tractor Trailer)	17549	B	4854	27.90	5178	29.76	5501	31.61	5825	33.48	6149	35.34	6472	37.20
Heavy Construction Equipment Operator (Regular – RG)	18465	Q	4739	27.24	5054	29.05	5370	30.86	5687	32.68	6002	34.49	6318	36.31
Heavy Construction Equipment Operator (Bridge Crew – BC)	18465	Q	4806	27.62	5127	29.47	5448	31.31	5768	33.15	6088	34.99	6409	36.83
Highway Maintainer (Regular – RG)	18639	Q	4641	26.67	4950	28.45	5259	30.22	5568	32.00	5878	33.78	6187	35.56
Highway Maintainer (Bridge Crew – BC)	18639	Q	4711	27.07	5026	28.89	5340	30.69	5654	32.49	5968	34.30	6282	36.10
Highway Maintainer (Drill Rig – DR)	18639	Q	4739	27.24	5054	29.05	5370	30.86	5687	32.68	6002	34.49	6318	36.31
Highway Maintainer (Emergency Patrol – EP)	18639	Q	4741	27.25	5057	29.06	5378	30.87	5689	32.70	6005	34.51	6321	36.33
Highway Maintenance Lead Worker (Regular – RG)	18659	Q	4770	27.41	5087	29.24	5405	31.06	5723	32.89	6040	34.71	6359	36.55
Highway Maintenance Lead Worker (Bridge Crew – BC)	18659	Q	4837	27.80	5159	29.65	5483	31.51	5805	33.36	6127	35.21	6449	37.06
Highway Maintenance Lead Worker	18659	Q	4867	27.97	5192	29.84	5516	31.70	5841	33.57	6165	35.43	6489	37.29

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Emergency Patrol – EP) Highway Maintenance Lead Worker (Lead Lead Worker) (Regular – RG)	18659	Q	4817	27.68	5139	29.53	5459	31.37	5780	33.22	6102	35.07	6423	36.91
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew – BC)	18659	Q	4886	28.08	5211	29.95	5537	31.82	5862	33.69	6188	35.56	6514	37.44
Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol – EP)	18659	Q	4916	28.25	5244	30.14	5571	32.02	5899	33.90	6227	35.79	6555	37.67
Laborer (Maintenance) (Regular – RG)	23080	B	4492	25.82	4792	27.54	5091	29.26	5391	30.98	5690	32.70	5989	34.42
Maintenance Equipment Operator	25020	B	4583	26.34	4888	28.09	5194	29.85	5499	31.60	5805	33.36	6110	35.11
Maintenance Equipment Operator (DHS – Tractor Trailer)	25020	B	4605	26.47	4912	28.23	5219	30.95	5526	31.76	5833	33.52	6140	35.29
Maintenance Equipment Operator (Dispatcher)	25020	B	4751	27.30	5067	29.12	5385	29.99	5701	32.76	6018	34.59	6334	36.40
Maintenance Worker (not DOT, DHS – Chicago Read or DHS – Forensic)	25500	B	4440	25.52	4736	27.22	5032	28.92	5328	30.62	5624	32.32	5920	34.02
Maintenance Worker (DHS – Chicago Read)	25500	B	4583	26.34	4888	28.09	5194	29.85	5499	31.60	5805	33.36	6110	35.11

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Maintenance Worker (DHS – Forensic)	25500	Q	4641	26.67	4950	28.45	5259	30.22	5568	32.00	5878	33.78	6187	35.56
Maintenance Worker (DOT – Regular – RG)	25500	B	4529	26.03	4831	27.76	5133	29.50	5435	31.24	5736	32.97	6038	34.70
Maintenance Worker (DOT – Emergency Patrol – EP)	25500	B	4626	26.59	4934	28.36	5242	30.13	5550	31.90	5859	33.67	6167	35.44
Power Shovel Operator (Maintenance) (Regular – RG)	33360	B	4806	27.62	5127	29.47	5448	31.31	5768	33.15	6088	34.99	6409	36.83

NOTES: Shift Differential Pay – Employees (except Snowbirds) required to work a shift different than their normal day shift will be paid a \$0.50 per hour shift premium provided that ½ or more of their work shift falls before 6:30 a.m. or after 3:00 p.m. This shift premium does not include those employees normally working shifts other than the normal day shift or employees hired into positions where the regular shift hours are not considered day shift hours, or snow or ice season.

Clothing Allowance – Effective July 1, 2011, the clothing allowance for Lead Workers, Lead Lead Workers, Heavy Construction Equipment Operator, Highway Maintainers, and Maintenance Workers (Illinois Department of Transportation) employees increases to \$200.

Stipend – Employees shall receive a one-time 2.25% stipend that will not be added into the base salary effective June 1, 2013. Permanent part-time employees will be paid a pro-rated stipend based upon their regular work schedule, which will not be added into the base salary. To be eligible for the stipend, the employee must be on payroll June 1, 2013. Employees on leave of absence who would otherwise be eligible will receive the lump sum stipend to which they are entitled upon return to the active payroll during fiscal year 2013. An employee, who worked during fiscal year 2013, which dates are July 1, 2012 through June 30, 2013, and were on an authorized Worker's Compensation Leave of Absence, shall be paid the fiscal year 2013 stipend upon their official return to work sometime during fiscal year 2014, unless otherwise compensated for the stipend. Return to work is defined as the employee's first day back to active payroll status with an authorized licensed physician's release.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

In-Hire Rate – In-hire rates are located in Section 310.47(a). Employees who are promoted and are in the in-hire progression will promote to the next step of the in-hire rate of the higher classification. In addition, temporary assignments shall also be calculated at the in-hire rates. Employees in the in-hire will receive a 5% increase each year for five years on their anniversary date in order to obtain the full rate. All full scale employees will be promoted to the full-scale rate of the next higher classifications, upon promotion.

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE D HR-001 (Teamsters Local #700)**

Title	Title Code	Bargaining Unit	Pay Plan Code	Full Scale Mo.	Effective Date
<u>Highway Maintainer (Snowbirds)</u>	<u>18639</u>	<u>HR-001</u>	<u>Q</u>	<u>4289.00</u>	<u>October 1, 2013</u>
<u>Highway Maintainer (Snowbirds)</u>	<u>18639</u>	<u>HR-001</u>	<u>Q</u>	<u>4375.00</u>	<u>July 1, 2014</u>
Highway Maintainer (Snowbirds)	18639	HR-001	Q	4205.00	June 30, 2012

NOTE: Definition of Snowbirds – Snowbirds are all seasonal, full-time Highway Maintainers whose primary function is snow removal.

Effective July 1, 2014

Title	Title Code	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.								
Building Services Worker	05616	B	2951	16.96	3148	18.09	3344	19.22	3540	20.34	3737	21.48	3934	22.61
Elevator Operator	13500	B	3011	17.30	3212	18.46	3413	19.61	3613	20.76	3814	21.92	4015	23.07
Elevator Operator – Assistant Starter	13500	B	3050	17.53	3254	18.70	3457	19.87	3660	21.03	3864	22.21	4067	23.37
Elevator Operator – Starter	13500	B	3069	17.64	3274	18.82	3478	19.99	3683	21.17	3887	22.34	4092	23.52
Grounds Supervisor	17549	B	4471	25.70	4769	27.41	5066	29.11	5365	30.83	5663	32.55	5961	34.26
Grounds Supervisor (DHS – Chicago Read)	17549	B	4633	26.63	4942	28.40	5251	30.18	5559	31.95	5868	33.72	6177	35.50
Grounds Supervisor (DHS –	17549	B	4854	27.90	5178	29.76	5501	31.61	5825	33.48	6149	35.34	6472	37.20

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Supervisor Tractor Trailer)														
Heavy Construction Equipment Operator (Regular – RG)	18465	Q	4739	27.24	5054	29.05	5370	30.86	5687	32.68	6002	34.49	6318	36.31
Heavy Construction Equipment Operator (Bridge Crew – BC)	18465	Q	4806	27.62	5127	29.47	5448	31.31	5768	33.15	6088	34.99	6409	36.83
Highway Maintainer (Regular – RG)	18639	Q	4641	26.67	4950	28.45	5259	30.22	5568	32.00	5878	33.78	6187	35.56
Highway Maintainer (Bridge Crew – BC)	18639	Q	4711	27.07	5026	28.89	5340	30.69	5654	32.49	5968	34.30	6282	36.10
Highway Maintainer (Drill Rig – DR)	18639	Q	4739	27.24	5054	29.05	5370	30.86	5687	32.68	6002	34.49	6318	36.31
Highway Maintainer (Emergency Patrol – EP)	18639	Q	4741	27.25	5057	29.06	5378	30.87	5689	32.70	6005	34.51	6321	36.33
Highway Maintenance Lead Worker (Regular – RG)	18659	Q	4770	27.41	5087	29.24	5405	31.06	5723	32.89	6040	34.71	6359	36.55
Highway Maintenance Lead Worker (Bridge Crew – BC)	18659	Q	4837	27.80	5159	29.65	5483	31.51	5805	33.36	6127	35.21	6449	37.06
Highway Maintenance Lead Worker (Emergency Patrol – EP)	18659	Q	4867	27.97	5192	29.84	5516	31.70	5841	33.57	6165	35.43	6489	37.29
Highway Maintenance Lead Worker (Lead Lead	18659	Q	4817	27.68	5139	29.53	5459	31.37	5780	33.22	6102	35.07	6423	36.91

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Worker) (Regular – RG) Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew – BC)	18659	Q	4886	28.08	5211	29.95	5537	31.82	5862	33.69	6188	35.56	6514	37.44
Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol – EP)	18659	Q	4916	28.25	5244	30.14	5571	32.02	5899	33.90	6227	35.79	6555	37.67
Laborer (Maintenance) (Regular – RG)	23080	B	4492	25.82	4792	27.54	5091	29.26	5391	30.98	5690	32.70	5989	34.42
Maintenance Equipment Operator	25020	B	4583	26.34	4888	28.09	5194	29.85	5499	31.60	5805	33.36	6110	35.11
Maintenance Equipment Operator (DHS – Tractor Trailer)	25020	B	4605	26.47	4912	28.23	5219	30.95	5526	31.76	5833	33.52	6140	35.29
Maintenance Equipment Operator (Dispatcher)	25020	B	4751	27.30	5067	29.12	5385	29.99	5701	32.76	6018	34.59	6334	36.40
Maintenance Worker (not DOT, DHS – Chicago Read or DHS – Forensic)	25500	B	4440	25.52	4736	27.22	5032	28.92	5328	30.62	5624	32.32	5920	34.02
Maintenance Worker (DHS – Chicago Read)	25500	B	4583	26.34	4888	28.09	5194	29.85	5499	31.60	5805	33.36	6110	35.11
Maintenance Worker (DHS – Forensic)	25500	Q	4641	26.67	4950	28.45	5259	30.22	5568	32.00	5878	33.78	6187	35.56
Maintenance Worker (DOT	25500	B	4529	26.03	4831	27.76	5133	29.50	5435	31.24	5736	32.97	6038	34.70

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

– Regular – RG)														
Maintenance														
Worker (DOT														
– Emergency														
Patrol – EP)	25500	B	4626	26.59	4934	28.36	5242	30.13	5550	31.90	5859	33.67	6167	35.44
Power Shovel														
Operator														
(Maintenance)														
(Regular – RG)	33360	B	4806	27.62	5127	29.47	5448	31.31	5768	33.15	6088	34.99	6409	36.83

NOTES: Shift Differential Pay – Employees (except Snowbirds) required to work a shift different than their normal day shift will be paid a \$0.50 per hour shift premium provided that ½ or more of their work shift falls before 6:30 a.m. or after 3:00 p.m. This shift premium does not include those employees normally working shifts other than the normal day shift or employees hired into positions where the regular shift hours are not considered day shift hours, or snow or ice season.

Clothing Allowance – Effective July 1, 2011, the clothing allowance for Lead Workers, Lead Lead Workers, Heavy Construction Equipment Operator, Highway Maintainers, and Maintenance Workers (Illinois Department of Transportation) employees increases to \$200.

Stipend – Employees shall receive a one-time 2.25% stipend that will not be added into the base salary effective June 1, 2013. Permanent part-time employees will be paid a pro-rated stipend based upon their regular work schedule, which will not be added into the base salary. To be eligible for the stipend, the employee must be on payroll June 1, 2013. Employees on leave of absence who would otherwise be eligible will receive the lump sum stipend to which they are entitled upon return to the active payroll during fiscal year 2013. An employee, who worked during fiscal year 2013, which dates are July 1, 2012 through June 30, 2013, and were on an authorized Worker's Compensation Leave of Absence, shall be paid the fiscal year 2013 stipend upon their official return to work sometime during fiscal year 2014, unless otherwise compensated for the stipend. Return to work is defined as the employee's first day back to active payroll status with an authorized licensed physician's release.

In-Hire Rate – In-hire rates are located in Section 310.47(a). Employees who are promoted and are in the in-hire progression will promote to the next step of the in-hire rate of the higher classification. In addition, temporary assignments shall also be calculated at the in-hire rates. Employees in the in-hire will receive a 5% increase each

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

year for five years on their anniversary date in order to obtain the full rate. All full scale employees will be promoted to the full-scale rate of the next higher classifications, upon promotion.

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE F RC-019 (Teamsters Local #25)**

Title	Title Code	Bargaining Unit	Pay Plan Code	Full Scale Mo.	Effective Date
Highway Maintainer (Snowbirds)	18639	RC-019	Q	3664.00	January 1, 2010
Highway Maintainer (Snowbirds)	18639	RC-019	Q	3738.00	July 1, 2010
Highway Maintainer (Snowbirds)	18639	RC-019	Q	3850.00	January 1, 2011
Highway Maintainer (Snowbirds)	18639	RC-019	Q	3964.00	July 1, 2011
Highway Maintainer (Snowbirds)	18639	RC-019	Q	4083.00	January 1, 2012
Highway Maintainer (Snowbirds)	18639	RC-019	Q	4205.00	June 30, 2012

NOTE: Definition of Snowbird – Snowbirds are all seasonal, salaried, full-time Highway Maintainers whose primary function is snow removal.

Effective July 1, 2012

Title	Title Code	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.								
Bridge Mechanic (IDOT)	05310	Q										5982	34.38	
Bridge Tender (IDOT)	05320	B										6018	34.59	
Deck Hand (IDOT)	11500	B										5782	33.23	
Ferry Operator I (IDOT)	14801	B										6018	34.59	
Ferry Operator II (IDOT)	14802	B										6070	34.89	
Highway Maintainer (Regular—RG) (IDOT)	18639	Q	4460	25.63	4758	27.34	5055	29.05	5352	30.76	5650	32.47	5947	34.18
Highway Maintainer (Bridge Crew—BC) (IDOT)	18639	Q	4517	25.96	4818	27.69	5119	29.42	5420	31.15	5721	32.88	6022	34.61

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Highway Maintainer (Drill Rig—DR) (IDOT)	18639	Q	4539	26.09	4842	27.83	5144	29.56	5447	31.30	5749	33.04	6052	34.78
Highway Maintainer (Emergency Patrol—EP) (IDOT)	18639	Q	4541	26.10	4843	27.83	5146	29.57	5449	31.32	5751	33.05	6054	34.79
Highway Maintenance Lead Worker (Regular—RG) (IDOT)	18659	Q											6085	34.97
Highway Maintenance Lead Worker (Bridge Crew— BC)(IDOT)	18659	Q											6159	35.40
Highway Maintenance Lead Worker (Emergency Patrol—EP) (IDOT)	18659	Q											6192	35.59
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular—RG) (IDOT)	18659	Q											6138	35.28
Highway Maintenance Lead Worker (Lead Lead Worker)(Bridge Crew—BC) (IDOT)	18659	Q											6212	35.70
Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency	18659	Q											6217	35.73

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Patrol—EP)
(IDOT)

Janitor I (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21951	B	5574	32.03
Janitor II (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21952	B	5607	32.22
Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	22809	B	5844	33.59
Laborer (Maintenance) (IDOT)	23080	B	5785	33.25
Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	25020	B	5882	33.80
Maintenance Equipment Operator (DOC & DJJ)	25020	Q	6052	34.78
Maintenance Equipment Operator (DOC	25020	S	6105	35.09

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—Maximum Security)				
Maintenance Equipment Operator (DHS— Forensics)	25020	Q	5947	34.18
Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	25500	B	5823	33.47
Maintenance Worker (DHS— Forensics)	25500	Q	5888	33.84
Power Shovel Operator (Maintenance) (Regular—RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	33360	B	5986	34.40
Power Shovel Operator (Maintenance) (Regular—RG) (IDOT)	33360	Q	6052	34.78
Power Shovel Operator (Maintenance) (Bridge Crew— BC) (IDOT)	33360	Q	6127	35.21
Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39851	B	5603	32.20
Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39852	B	5653	32.49
Silk Screen Operator (IDOT)	41020	B	5991	34.43

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Effective July 1, 2013

Title	Title	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.								
Bridge Mechanic (IDOT)	05310	Q											6102	35.07
Bridge Tender (IDOT)	05320	B											6138	35.28
Deck Hand (IDOT)	11500	B											5898	33.90
Ferry Operator I (IDOT)	14801	B											6138	35.28
Ferry Operator II (IDOT)	14802	B											6191	35.58
Highway Maintainer (Regular—RG) (IDOT)	18639	Q	4550	26.15	4853	27.89	5156	29.63	5459	31.37	5763	33.12	6066	34.86
Highway Maintainer (Bridge Crew— BC)(IDOT)	18639	Q	4607	26.48	4914	28.24	5221	30.01	5528	31.77	5835	33.53	6142	35.30
Highway Maintainer (Drill Rig—DR) (IDOT)	18639	Q	4630	26.61	4938	28.38	5247	30.16	5556	31.93	5864	33.70	6173	35.48
Highway Maintainer (Emergency Patrol—EP) (IDOT)	18639	Q											6175	35.49
Highway Maintenance Lead Worker (Regular—RG) (IDOT)	18659	Q											6207	35.67
Highway Maintenance Lead Worker (Bridge Crew— BC)(IDOT)	18659	Q											6282	36.10

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Highway Maintenance Lead Worker (Emergency Patrol—EP) (IDOT)	18659	Q	6316	36.30
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular—RG) (IDOT)	18659	Q	6261	35.98
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew— BC) (IDOT)	18659	Q	6336	36.41
Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol—EP) (IDOT)	18659	Q	6341	36.44
Janitor I (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21951	B	5685	32.67
Janitor II (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21952	B	5719	32.87

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Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	22809	B	5961	34.26
Laborer (Maintenance) (IDOT)	23080	B	5901	33.91
Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	25020	B	6000	34.48
Maintenance Equipment Operator (DOC & DJJ)	25020	Q	6173	35.48
Maintenance Equipment Operator (DOC —Maximum Security)	25020	S	6227	35.79
Maintenance Equipment Operator (DHS —Forensics)	25020	Q	6066	34.86
Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	25500	B	5939	34.13
Maintenance Worker (DHS— Forensics)	25500	Q	6006	34.52
Power Shovel Operator (Maintenance) (Regular—RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	33360	B	6106	35.09

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Highway Maintainer (Bridge Crew— BC) (IDOT)	18639	Q	4607	26.48	4914	28.24	5221	30.01	5528	31.77	5835	33.53	6142	35.30
Highway Maintainer (Drill Rig—DR) (IDOT)	18639	Q	4630	26.61	4938	28.38	5247	30.16	5556	31.93	5864	33.70	6173	35.48
Highway Maintainer (Emergency Patrol—EP) (IDOT)	18639	Q	4631	26.61	4940	28.39	5249	30.17	5558	31.94	5866	33.71	6175	35.49
Highway Maintenance Lead Worker (Regular—RG) (IDOT)	18659	Q	4655	26.75	4966	28.54	5276	30.32	5586	32.10	5897	33.89	6207	35.67
Highway Maintenance Lead Worker (Bridge Crew— BC) (IDOT)	18659	Q	4712	27.08	5026	28.89	5340	30.69	5654	32.49	5968	34.30	6282	36.10
Highway Maintenance Lead Worker (Emergency Patrol—EP) (IDOT)	18659	Q	4737	27.22	5053	29.04	5369	30.86	5684	32.67	6000	34.48	6316	36.30
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular—RG) (IDOT)	18659	Q	4696	26.99	5009	28.79	5322	30.59	5635	32.39	5948	34.18	6261	35.98
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew— BC) (IDOT)	18659	Q	4752	27.31	5069	29.13	5386	30.95	5702	32.77	6019	34.59	6336	36.41

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Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol—EP) (IDOT)	18659	Q	4756	27.33	5073	29.16	5390	30.98	5707	32.80	6024	34.62	6341	36.44
Janitor I (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21951	B	4264	24.51	4548	26.14	4832	27.77	5117	29.41	5401	31.04	5685	32.67
Janitor II (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21952	B	4289	24.65	4575	26.29	4861	27.94	5147	29.58	5433	31.22	5719	32.87
Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	22809	B	4471	25.70	4769	27.41	5067	29.12	5365	30.83	5663	32.55	5961	34.26
Laborer (Maintenance) (IDOT)	23080	B	4426	25.44	4721	27.13	5016	28.83	5311	30.52	5606	32.22	5901	33.91
Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	25020	B	4500	25.86	4800	27.59	5100	29.31	5400	31.03	5700	32.76	6000	34.48
Maintenance Equipment Operator (DOC & DJJ)	25020	Q	4550	26.15	4853	27.89	5156	29.63	5459	31.37	5763	33.12	6173	35.48
Maintenance Equipment	25020	S	4630	26.61	4938	28.38	5247	30.16	5556	31.93	5864	33.70	6227	35.79

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Operator (DOC -Maximum Security) Maintenance Equipment Operator (DHS -Forensics)	25020	Q	4670	26.84	4982	28.63	5293	30.42	5604	32.21	5916	34.00	6066	34.86
Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	25500	B	4454	25.60	4751	27.30	5048	29.01	5345	30.72	5642	32.43	5939	34.13
Maintenance Worker (DHS- Forensics)	25500	Q	4505	25.89	4805	27.61	5105	29.34	5405	31.06	5706	32.79	6006	34.52
Power Shovel Operator (Maintenance) (Regular -RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	33360	B	4580	26.32	4885	28.07	5190	29.83	5495	31.58	5801	33.34	6106	35.09
Power Shovel Operator (Maintenance) (Regular -RG) (IDOT)	33360	Q	4630	26.61	4938	28.38	5247	30.16	5556	31.93	5864	33.70	6173	35.48
Power Shovel Operator (Maintenance) (Bridge Crew- BC) (IDOT)	33360	Q	4688	26.94	5000	28.74	5313	30.53	5625	32.33	5938	34.13	6250	35.92
Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39851	B	4286	24.63	4572	26.28	4858	27.92	5144	29.56	5429	31.20	5715	32.84
Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39852	B	4325	24.86	4613	26.51	4901	28.17	5189	29.82	5478	31.48	5766	33.14

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Silk Screen
Operator
(IDOT)

41020 B 4583 26.34 4889 28.10 5194 29.85 5500 31.61 5805 33.36 6111 35.12

Effective July 1, 2014

Title	Title	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.								
Bridge Mechanic (IDOT)	05310	Q	4668	26.83	4979	28.61	5290	30.40	5602	32.20	5913	33.98	6224	35.77
Bridge Tender (IDOT)	05320	B	4696	26.99	5009	28.79	5322	30.59	5635	32.39	5948	34.18	6261	35.98
Deck Hand (IDOT)	11500	B	4512	25.93	4813	27.66	5114	29.39	5414	31.11	5715	32.84	6016	34.57
Ferry Operator I (IDOT)	14801	B	4696	26.99	5009	28.79	5322	30.59	5635	32.39	5948	34.18	6261	35.98
Ferry Operator II (IDOT)	14802	B	4736	27.22	5052	29.03	5368	30.85	5684	32.67	5999	34.48	6315	36.29
Highway Maintainer (Regular - RG) (IDOT)	18639	Q	4640	26.67	4950	28.45	5259	30.22	5568	32.00	5878	33.78	6187	35.56
Highway Maintainer (Bridge Crew - BC) (IDOT)	18639	Q	4699	27.01	5012	28.80	5325	30.60	5639	32.41	5952	34.21	6265	36.01
Highway Maintainer (Drill Rig - DR) (IDOT)	18639	Q	4722	27.14	5037	28.95	5352	30.76	5666	32.56	5981	34.37	6296	36.18
Highway Maintainer (Emergency Patrol - EP) (IDOT)	18639	Q	4724	27.15	5039	28.96	5354	30.77	5669	32.58	5984	34.39	6299	36.20
Highway Maintenance Lead Worker (Regular - RG) (IDOT)	18659	Q	4748	27.29	5065	29.11	5381	30.93	5698	32.75	6014	34.56	6331	36.39

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Highway Maintenance Lead Worker (Bridge Crew - BC) (IDOT)	18659	Q	4806	27.62	5126	29.46	5447	31.30	5767	33.14	6088	34.99	6408	36.83
Highway Maintenance Lead Worker (Emergency Patrol - EP) (IDOT)	18659	Q	4832	27.77	5154	29.62	5476	31.47	5798	33.32	6120	35.17	6442	37.02
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular - RG) (IDOT)	18659	Q	4790	27.53	5109	29.36	5428	31.20	5747	33.03	6067	34.87	6386	36.70
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew - BC) (IDOT)	18659	Q	4847	27.86	5170	29.71	5494	31.57	5817	33.43	6140	35.29	6463	37.14
Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol - EP) (IDOT)	18659	Q	4851	27.88	5174	29.74	5498	31.60	5821	33.45	6145	35.32	6468	37.17
Janitor I (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21951	B	4349	24.99	4639	26.66	4929	28.33	5219	29.99	5509	31.66	5799	33.33
Janitor II (Including Office of Administration) (CMS, DOC,	21952	B	4375	25.14	4666	26.82	4958	28.49	5250	30.17	5541	31.84	5833	33.52

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DHS, DJJ, DNR, ISP and DVA)														
Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	22809	B	4560	26.21	4864	27.95	5168	29.70	5472	31.45	5776	33.20	6080	34.94
Laborer (Maintenance) (IDOT)	23080	B	4514	25.94	4815	27.67	5116	29.40	5417	31.13	5718	32.86	6019	34.59
Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	25020	B	4590	26.38	4896	28.14	5202	29.90	5508	31.66	5814	33.41	6120	35.17
Maintenance Equipment Operator (DOC & DJJ)	25020	Q	4640	26.67	4950	28.45	5259	30.22	5568	32.00	5878	33.78	6296	36.18
Maintenance Equipment Operator (DOC - Maximum Security)	25020	S	4722	27.14	5037	28.95	5352	30.76	5666	32.56	5981	34.37	6352	36.51
Maintenance Equipment Operator (DHS - Forensics)	25020	Q	4764	27.38	5082	29.21	5399	31.03	5717	32.86	6034	34.68	6187	35.56
Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	25500	B	4544	26.11	4846	27.85	5149	29.59	5452	31.33	5755	33.07	6058	34.82
Maintenance Worker (DHS - Forensics)	25500	Q	4595	26.41	4901	28.17	5207	29.93	5513	31.68	5820	33.45	6126	35.21

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Power Shovel Operator (Maintenance) (Regular - RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	33360	B	4671	26.84	4982	28.63	5294	30.43	5605	32.21	5917	34.01	6228	35.79
Power Shovel Operator (Maintenance) (Regular - RG) (IDOT)	33360	Q	4722	27.14	5037	28.95	5352	30.76	5666	32.56	5981	34.37	6296	36.18
Power Shovel Operator (Maintenance) (Bridge Crew - BC) (IDOT)	33360	Q	4781	27.48	5100	29.31	5419	31.14	5738	32.98	6056	34.80	6375	36.64
Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39851	B	4372	25.13	4663	26.80	4955	28.48	5246	30.15	5538	31.83	5829	33.50
Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39852	B	4411	25.35	4705	27.04	4999	28.73	5293	30.42	5587	32.11	5881	33.80
Silk Screen Operator (IDOT)	41020	B	4675	26.87	4986	28.66	5298	30.45	5610	32.24	5921	34.03	6233	35.82

NOTES: Shift Differential Pay – Employees required to work a shift different than their normal day shift will be paid a \$0.50 per hour shift premium, provided that ½ or more of their work shift falls before 6:30 a.m. or after 3:00 p.m. This shift premium does not include those employees normally working shifts other than the normal day shift or employees hired into positions for which the regular shift hours are not considered day shift hours, or snow or ice season.

Clothing Allowance – Effective July 1, 2011, the clothing allowance for Highway Maintainers, Highway Maintenance Lead Workers, Highway Maintenance Lead Lead Workers, Deck Hands and Power Shovel Operator Maintenance employees increases to \$200. Effective July 1, 2011, the clothing allowance for all other titles increases to \$100. Effective July 1, 2013, employees who are required to wear steel-toe safety

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shoes shall receive an additional \$100 clothing allowance. The total will not exceed \$200 per contract year.

Stipend – Employees shall receive a one-time 2.25% stipend that will not be added into the base salary effective June 1, 2013. Permanent part-time employees will be paid a prorated stipend based upon their regular work schedule, which will not be added into the base salary. To be eligible for the stipend, the employee must be on payroll June 1, 2013. Employees on leave of absence who would otherwise be eligible will receive the lump sum stipend to which they are entitled upon return to the active payroll during fiscal year 2013. An employee who worked during fiscal year 2013 (July 1, 2012 through June 30, 2013) and was on an authorized Worker's Compensation Leave of Absence, shall be paid the fiscal year 2013 stipend upon the employee's official return to work sometime during fiscal year 2014, unless otherwise compensated for the stipend. Return to work is defined as the employee's first day back to active payroll status with an authorized licensed physician's release.

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE G RC-045 (Automotive Mechanics, IFPE)****Effective July 1, 2012**

<u>Title</u>	<u>Title Code</u>	<u>Pay Plan Code</u>	<u>Monthly Rate</u>
Auto & Body Repairer	03680	B	5432
Auto & Body Repairer	03680	Q	5624
Auto & Body Repairer	03680	S	5704
Automotive Attendant I	03696	B	3281
Automotive Attendant I	03696	Q	3411
Automotive Attendant I	03696	S	3484
Automotive Attendant II	03697	B	3504
Automotive Attendant II	03697	Q	3642
Automotive Attendant II	03697	S	3714
Automotive Mechanic	03700	B	5432
Automotive Mechanic	03700	Q	5624
Automotive Mechanic	03700	S	5704
Automotive Mechanic (Hired on or after 9/1/2010)	03700	B	5052
Automotive Mechanic (Hired on or after 9/1/2010)	03700	Q	5230
Automotive Mechanic (Hired on or after 9/1/2010)	03700	S	5305
Automotive Parts Warehouse Specialist	03734	B	5319
Automotive Parts Warehouse	03730	B	5218
Small Engine Mechanic	41150	B	4782
Storekeeper I (See Note)	43051	B	5112
Storekeeper II (See Note)	43052	B	5221

~~NOTES: Shift Differential Pay—Regular shifts that commence at or after 4:00 p.m. shall be considered night shifts and employees on those shifts shall be paid at \$0.50 per hour above their normal rate of pay for all hours worked on those shifts. Effective January 1, 2003, the shift differential shall increase to \$0.65 per hour.~~

~~Storekeeper Clarification—Storekeeper I and II serve as an Automotive Parts Warehouse in Cook County. The Storekeeper I and II titles are in Cook County only.~~

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

~~Pension Formula Change—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 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).~~

~~Stipend—Employees shall receive a one-time 2.25% stipend that will not be added into the base salary. The stipend is based on the employee's base salary effective June 28, 2013. Permanent part-time employees are paid a pro-rated stipend, based upon their regular work schedule, that is not to be added into the employee's base salary. To be eligible for the stipend, the employee shall be on the payroll June 28, 2013. Employees on leave of absence who would otherwise be eligible will receive the lump sum stipend upon return during fiscal year 2013 to the active payroll.~~

Effective July 1, 2013

Title	Title Code	Pay Plan Code	93%	95%	97%	100% (Full Scale)
Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	B	5153	5264	5375	5541

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Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	Q	5230	5343	5455	5624
Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	S	5305	5419	5533	5704

Title	Title Code	Pay Plan Code	75%	80%	85%	90%	95%	100% (Full-Scale)
Auto & Body Repairer	03680	B	4156	4433	4710	4987	5264	5541
Auto & Body Repairer	03680	Q	4218	4499	4780	5062	5343	5624
Auto & Body Repairer	03680	S	4278	4563	4848	5134	5419	5704
Automotive Attendant I	03696	B	2510	2678	2845	3012	3180	3347
Automotive Attendant I	03696	Q	2558	2729	2899	3070	3240	3411
Automotive Attendant I	03696	S	2613	2787	2961	3136	3310	3484
Automotive Attendant II	03697	B	2681	2859	3038	3217	3395	3574
Automotive Attendant II	03697	Q	2732	2914	3096	3278	3460	3642
Automotive Attendant II	03697	S	2786	2971	3157	3343	3528	3714
Automotive Mechanic	03700	B	4156	4433	4710	4987	5264	5541
Automotive Mechanic	03700	Q	4218	4499	4780	5062	5343	5624
Automotive Meehanic	03700	S	4278	4563	4848	5134	5419	5704
Automotive Parts Warehouse Specialist	03734	B	4069	4340	4611	4883	5154	5425
Automotive Parts Warehouse	03730	B	3992	4258	4524	4790	5056	5322
Small Engine Mechanic	41150	B	3659	3902	4146	4390	4634	4878
Storekeeper I (See Note)	43051	B	3911	4171	4432	4693	4953	5214
Storekeeper II (See Note)	43052	B	3994	4260	4526	4793	5059	5325

Effective July 1, 2014

Title	Title Code	Pay Plan Code	95%	97%	100% (Full-Scale)
Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	B	5369	5482	5652
Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	Q	5449	5564	5736

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Storekeeper Clarification – Storekeeper I and II serve as an Automotive Parts Warehouse in Cook County. The Storekeeper I and II titles are in Cook County only.

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

Pension Formula Change – 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 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).

Stipend – Employees shall receive a one-time 2.25% stipend that will not be added into the base salary. The stipend is based on the employee's base salary effective June 28, 2013. Permanent part-time employees are paid a prorated stipend, based upon their regular work schedule, which is not to be added into the employee's base salary. To be eligible for the stipend, the employee shall be on the payroll June 28, 2013. Employees on leave of absence who would otherwise be eligible will receive the lump sum stipend upon return during fiscal year 2013 to the active payroll.

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE H RC-006 (Corrections Employees, AFSCME)**

Title	Title Code	Bargaining Unit	Pay Grade
Canine Specialist	06500	RC-006	14
Correctional Officer	09675	RC-006	09
Correctional Officer Trainee	09676	RC-006	05
Correctional Sergeant	09717	RC-006	12
Corrections Clerk I	09771	RC-006	09
Corrections Clerk II	09772	RC-006	11
Corrections Food Service Supervisor I	09793	RC-006	11
Corrections Food Service Supervisor II	09794	RC-006	13
Corrections Grounds Supervisor	09796	RC-006	12
Corrections Identification Technician	09801	RC-006	11
Corrections Industry Lead Worker	09805	RC-006	12
Corrections Laundry Manager I	09808	RC-006	13
Corrections Locksmith	09818	RC-006	12
Corrections Maintenance Craftsman	09821	RC-006	12
Corrections Maintenance Worker	09823	RC-006	10
Corrections Medical Technician	09824	RC-006	10
Corrections Residence Counselor I	09837	RC-006	11
Corrections Supply Supervisor I	09861	RC-006	11
Corrections Supply Supervisor II	09862	RC-006	13
Corrections Transportation Officer I	09871	RC-006	11
Corrections Transportation Officer II	09872	RC-006	14
Corrections Utilities Operator	09875	RC-006	12
Corrections Vocational Instructor	09879	RC-006	12
Educator Aide	13130	RC-006	06
Housekeeper II	19602	RC-006	02
Juvenile Justice Specialist	21971	RC-006	14
Juvenile Justice Specialist Intern	21976	RC-006	11
Pest Control Operator	31810	RC-006	06
Property and Supply Clerk II	34792	RC-006	04
Social Service Aide Trainee	41285	RC-006	01
Storekeeper I	43051	RC-006	07
Storekeeper II	43052	RC-006	08

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Stores Clerk	43060	RC-006	03
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NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall have the percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours that would otherwise qualify them for premium pay under this provision.

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three (3) or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, the Step 8 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three 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 15 years of continuous service and have three 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 per month to \$100 a month.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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-006

Pay Grade	Pay Plan Code	STEPS							
		1	2	3	4	5	6	7	8
01	Q	2963	3043	3120	3193	3279	3350	3488	3630
01	S	3039	3115	3195	3261	3350	3421	3563	3705
02	Q	3040	3116	3192	3272	3355	3433	3577	3719
02	S	3112	3191	3260	3345	3429	3504	3647	3794
03	Q	3116	3193	3285	3367	3448	3537	3678	3824
03	S	3191	3261	3357	3439	3520	3610	3753	3904
04	Q	3193	3287	3371	3470	3560	3652	3812	3966
04	S	3261	3361	3443	3540	3630	3726	3887	4042
05	Q	3399	3503	3616	3725	3845	3959	4144	4311
05	S	3472	3577	3691	3802	3919	4033	4225	4393
06	Q	3588	3725	3847	3972	4103	4234	4461	4638
06	S	3663	3802	3920	4048	4182	4317	4540	4722

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

07	Q	3612	3725	3858	3971	4115	4234	4452	4631
07	S	3687	3802	3931	4046	4192	4317	4531	4712
08	Q	3874	4017	4157	4319	4467	4610	4865	5059
08	S	3947	4091	4235	4400	4546	4694	4948	5144
09	Q	3879	4022	4168	4333	4484	4648	4901	5099
09	S	3955	4098	4250	4412	4568	4731	4983	5182
10	Q	4032	4183	4357	4524	4694	4867	5142	5350
10	S	4114	4263	4438	4603	4777	4951	5223	5434
11	Q	4219	4393	4563	4756	4937	5126	5422	5639
11	S	4297	4472	4640	4839	5017	5214	5503	5724
12	Q	4395	4579	4779	4976	5171	5364	5675	5901
12	S	4474	4662	4863	5056	5257	5445	5757	5986
13	Q	4596	4805	5021	5232	5446	5669	5996	6233
13	S	4679	4889	5106	5319	5531	5750	6077	6322
14	Q	4670	4888	5109	5320	5537	5757	6096	6337
14	S	4753	4971	5192	5404	5620	5836	6178	6425
15	Q	4823	5048	5275	5495	5727	5956	6297	6548
15	S	4904	5131	5362	5579	5815	6038	6381	6638

Effective May 20, 2013
Bargaining Unit: RC-006

Pay Grade	Pay Plan Code	STEPS									
		1e	1b	1a	1	2	3	4	5	6	7

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

1	Q	2696	2785	2874	2963	3043	3120	3193	3279	3350	3488	3630
1	S	2765	2857	2948	3039	3115	3195	3261	3350	3421	3563	3705
2	Q	2766	2858	2949	3040	3116	3192	3272	3355	3433	3577	3719
2	S	2832	2925	3019	3112	3191	3260	3345	3429	3504	3647	3794
3	Q	2836	2929	3023	3116	3193	3285	3367	3448	3537	3678	3824
3	S	2904	3000	3095	3191	3261	3357	3439	3520	3610	3753	3904
4	Q	2906	3001	3097	3193	3287	3371	3470	3560	3652	3812	3966
4	S	2968	3065	3163	3261	3361	3443	3540	3630	3726	3887	4042
5	Q	3093	3195	3297	3399	3503	3616	3725	3845	3959	4144	4311
5	S	3160	3264	3368	3472	3577	3691	3802	3919	4033	4225	4393
6	Q	3265	3373	3480	3588	3725	3847	3972	4103	4234	4461	4638
6	S	3333	3443	3553	3663	3802	3920	4048	4182	4317	4540	4722
7	Q	3287	3395	3504	3612	3725	3858	3971	4115	4234	4452	4631
7	S	3355	3466	3576	3687	3802	3931	4046	4192	4317	4531	4712
8	Q	3525	3642	3758	3874	4017	4157	4319	4467	4610	4865	5059
8	S	3592	3710	3829	3947	4091	4235	4400	4546	4694	4948	5144
9	Q	3530	3646	3763	3879	4022	4168	4333	4484	4648	4901	5099
9	S	3599	3718	3836	3955	4098	4250	4412	4568	4731	4983	5182
10	Q	3669	3790	3911	4032	4183	4357	4524	4694	4867	5142	5350
10	S	3744	3867	3991	4114	4263	4438	4603	4777	4951	5223	5434
11	Q	3839	3966	4092	4219	4393	4563	4756	4937	5126	5422	5639
11	S	3910	4039	4168	4297	4472	4640	4839	5017	5214	5503	5724
12	Q	3999	4131	4263	4395	4579	4779	4976	5171	5364	5675	5901

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

12	S	4071	4206	4340	4474	4662	4863	5056	5257	5445	5757	5986
13	Q	4182	4320	4458	4596	4805	5021	5232	5446	5669	5996	6233
13	S	4258	4398	4539	4679	4889	5106	5319	5531	5750	6077	6322
14	Q	4250	4390	4530	4670	4888	5109	5320	5537	5757	6096	6337
14	S	4325	4468	4610	4753	4971	5192	5404	5620	5836	6178	6425
15	Q	4389	4534	4678	4823	5048	5275	5495	5727	5956	6297	6548
15	S	4463	4610	4757	4904	5131	5362	5579	5815	6038	6381	6638

Effective July 1, 2013
Bargaining Unit: RC-006

Pay Grade	Pay Plan Code	S T E P S										
		1e	1b	1a	1	2	3	4	5	6	7	8
1	Q	2750	2841	2931	3022	3104	3182	3257	3345	3417	3558	3703
1	S	2820	2914	3007	3100	3177	3259	3326	3417	3489	3634	3779
2	Q	2821	2915	3008	3101	3178	3256	3337	3422	3502	3649	3793
2	S	2889	2984	3079	3174	3255	3325	3412	3498	3574	3720	3870
3	Q	2893	2988	3083	3178	3257	3351	3434	3517	3608	3752	3900
3	S	2962	3060	3157	3255	3326	3424	3508	3590	3682	3828	3982
4	Q	2964	3061	3159	3257	3353	3438	3539	3631	3725	3888	4045
4	S	3027	3126	3226	3326	3428	3512	3611	3703	3801	3965	4123
5	Q	3155	3259	3363	3467	3573	3688	3800	3922	4038	4227	4397
5	S	3223	3329	3435	3541	3649	3765	3878	3997	4114	4310	4481
6	Q	3330	3440	3550	3660	3800	3924	4051	4185	4319	4550	4731
6	S	3400	3512	3624	3736	3878	3998	4129	4266	4403	4631	4816

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

7	Q	3353	3463	3574	3684	3800	3935	4050	4197	4319	4541	4724
7	S	3422	3535	3648	3761	3878	4010	4127	4276	4403	4622	4806
8	Q	3596	3715	3833	3951	4097	4240	4405	4556	4702	4962	5160
8	S	3664	3784	3906	4026	4173	4320	4488	4637	4788	5047	5247
9	Q	3601	3719	3838	3957	4102	4251	4420	4574	4741	4999	5201
9	S	3671	3792	3913	4034	4180	4335	4500	4659	4826	5083	5286
10	Q	3742	3866	3989	4113	4267	4444	4614	4788	4964	5245	5457
10	S	3819	3944	4071	4196	4348	4527	4695	4873	5050	5327	5543
11	Q	3916	4045	4174	4303	4481	4654	4851	5036	5229	5530	5752
11	S	3988	4120	4251	4383	4561	4733	4936	5117	5318	5613	5838
12	Q	4079	4214	4348	4483	4671	4875	5076	5274	5471	5789	6019
12	S	4152	4290	4427	4563	4755	4960	5157	5362	5554	5872	6106
13	Q	4266	4406	4547	4688	4901	5121	5337	5555	5782	6116	6358
13	S	4343	4486	4630	4773	4987	5208	5425	5642	5865	6199	6448
14	Q	4335	4478	4621	4763	4986	5211	5426	5648	5872	6218	6464
14	S	4412	4557	4702	4848	5070	5296	5512	5732	5953	6302	6554
15	Q	4477	4625	4772	4919	5149	5381	5605	5842	6075	6423	6679
15	S	4552	4702	4852	5002	5234	5469	5691	5931	6159	6509	6771

Effective July 1, 2014
Bargaining Unit: RC-006

STEPS

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Pay Grade	Pay Plan Code	1c	1b	1a	1	2	3	4	5	6	7	8
		1	Q	2805	2898	2990	3082	3166	3246	3322	3412	3485
1	S	2876	2972	3067	3162	3241	3324	3393	3485	3559	3707	3855
2	Q	2877	2973	3068	3163	3242	3321	3404	3490	3572	3722	3869
2	S	2947	3044	3141	3237	3320	3392	3480	3568	3645	3794	3947
3	Q	2951	3048	3145	3242	3322	3418	3503	3587	3680	3827	3978
3	S	3021	3121	3220	3320	3393	3492	3578	3662	3756	3905	4062
4	Q	3023	3122	3222	3322	3420	3507	3610	3704	3800	3966	4126
4	S	3088	3189	3291	3393	3497	3582	3683	3777	3877	4044	4205
5	Q	3218	3324	3430	3536	3644	3762	3876	4000	4119	4312	4485
5	S	3287	3396	3504	3612	3722	3840	3956	4077	4196	4396	4571
6	Q	3397	3509	3621	3733	3876	4002	4132	4269	4405	4641	4826
6	S	3468	3582	3696	3811	3956	4078	4212	4351	4491	4724	4912
7	Q	3420	3532	3645	3758	3876	4014	4131	4281	4405	4632	4818
7	S	3490	3606	3721	3836	3956	4090	4210	4362	4491	4714	4902
8	Q	3668	3789	3910	4030	4179	4325	4493	4647	4796	5061	5263
8	S	3737	3860	3984	4107	4256	4406	4578	4730	4884	5148	5352
9	Q	3673	3793	3915	4036	4184	4336	4508	4665	4836	5099	5305
9	S	3744	3868	3991	4115	4264	4422	4590	4752	4923	5185	5392
10	Q	3817	3943	4069	4195	4352	4533	4706	4884	5063	5350	5566
10	S	3895	4023	4152	4280	4435	4618	4789	4970	5151	5434	5654
11	Q	3994	4126	4257	4389	4571	4747	4948	5137	5334	5641	5867

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

11	S	4068	4202	4336	4471	4652	4828	5035	5219	5424	5725	5955
12	Q	4161	4298	4435	4573	4764	4973	5178	5379	5580	5905	6139
12	S	4235	4376	4516	4654	4850	5059	5260	5469	5665	5989	6228
13	Q	4351	4494	4638	4782	4999	5223	5444	5666	5898	6238	6485
13	S	4430	4576	4723	4868	5087	5312	5534	5755	5982	6323	6577
14	Q	4422	4568	4713	4858	5086	5315	5535	5761	5989	6342	6593
14	S	4500	4648	4796	4945	5171	5402	5622	5847	6072	6428	6685
15	Q	4567	4718	4867	5017	5252	5489	5717	5959	6197	6551	6813
15	S	4643	4796	4949	5102	5339	5578	5805	6050	6282	6639	6906

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE I RC-009 (Institutional Employees, AFSCME)**

Title	Title Code	Bargaining Unit	Pay Grade
Activity Program Aide I	00151	RC-009	03
Activity Program Aide II	00152	RC-009	05
Apparel/Dry Goods Specialist I	01231	RC-009	05
Apparel/Dry Goods Specialist II	01232	RC-009	09
Apparel/Dry Goods Specialist III	01233	RC-009	23
Clinical Laboratory Associate	08200	RC-009	09
Clinical Laboratory Phlebotomist	08213	RC-009	06
Clinical Laboratory Technician I	08215	RC-009	16
Clinical Laboratory Technician II	08216	RC-009	22
Cook I	09601	RC-009	07
Cook II	09602	RC-009	14
Educator Aide	13130	RC-009	19
Facility Assistant Fire Chief	14430	RC-009	21
Facility Fire Safety Coordinator	14435	RC-009	21
Facility Firefighter	14439	RC-009	16
Florist II	15652	RC-009	19
Institutional Maintenance Worker	21465	RC-009	10
Laboratory Assistant	22995	RC-009	02
Laboratory Associate I	22997	RC-009	16
Laboratory Associate II	22998	RC-009	22
Laundry Manager I	23191	RC-009	23
Licensed Practical Nurse I	23551	RC-009	16
Licensed Practical Nurse II	23552	RC-009	21
Locksmith	24300	RC-009	27
Mental Health Technician I	27011	RC-009	05
Mental Health Technician II	27012	RC-009	09
Mental Health Technician III	27013	RC-009	12
Mental Health Technician IV	27014	RC-009	14
Mental Health Technician V	27015	RC-009	17
Mental Health Technician VI	27016	RC-009	18
Mental Health Technician Trainee	27020	RC-009	01
Musician	28805	RC-009	12
Pest Control Operator	31810	RC-009	15

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Physical Therapy Aide I	32191	RC-009	04
Physical Therapy Aide II	32192	RC-009	10
Physical Therapy Aide III	32193	RC-009	17
Rehabilitation Workshop Instructor I	38192	RC-009	12
Rehabilitation Workshop Instructor II	38193	RC-009	20
Residential Care Worker	38277	RC-009	20
Residential Care Worker Trainee	38279	RC-009	11
Security Therapy Aide I	39901	RC-009	24
Security Therapy Aide II	39902	RC-009	25
Security Therapy Aide III	39903	RC-009	26
Security Therapy Aide IV	33904	RC-009	27
Security Therapy Aide Trainee	39905	RC-009	13
Social Service Aide I	41281	RC-009	12
Social Service Aide II	41282	RC-009	17
Social Service Aide Trainee	41285	RC-009	02
Support Service Coordinator I	44221	RC-009	15
Support Service Coordinator II	44222	RC-009	22
Support Service Lead	44225	RC-009	07
Support Service Worker	44238	RC-009	04
Transportation Officer	45830	RC-009	25
Veterans Nursing Assistant – Certified	47750	RC-009	12

NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall have that percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours that would otherwise qualify them for premium pay under this provision.

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous

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service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, the Step 8 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three 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 15 years of continuous service and have three 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 per month to \$100 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-009

Pay Grade	Pay Plan Code	STEPS							
		1	2	3	4	5	6	7	8

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01	B	2721	2783	2857	2924	2995	3066	3193	3320
01	Q	2828	2891	2967	3042	3113	3185	3320	3455
02	B	2783	2857	2934	2999	3082	3152	3285	3419
02	Q	2891	2967	3046	3117	3205	3276	3416	3553
03	B	2804	2891	2984	3076	3174	3276	3408	3546
03	Q	2912	3004	3102	3199	3303	3405	3545	3687
04	B	2852	2924	2998	3076	3157	3229	3366	3500
04	Q	2963	3042	3116	3199	3281	3359	3501	3641
05	B	2872	2961	3056	3152	3253	3357	3490	3632
05	Q	2988	3078	3178	3276	3384	3489	3631	3777
06	B	2939	3014	3095	3181	3262	3354	3495	3634
06	Q	3050	3132	3219	3309	3395	3485	3634	3780
07	B	2999	3091	3168	3261	3351	3438	3585	3728
07	Q	3117	3212	3297	3394	3483	3578	3736	3885
08	B	3014	3100	3191	3280	3368	3464	3621	3765
08	Q	3132	3222	3318	3409	3504	3602	3770	3921
09	B	3026	3120	3221	3321	3430	3542	3696	3843
09	Q	3147	3246	3349	3457	3568	3689	3848	4002
10	B	3091	3181	3271	3367	3460	3560	3725	3875
10	Q	3212	3309	3400	3503	3597	3706	3879	4035
11	B	3100	3198	3291	3395	3487	3586	3756	3907
11	Q	3222	3327	3422	3533	3627	3737	3912	4070
12	B	3116	3216	3318	3424	3533	3651	3811	3964

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NOTICE OF ADOPTED AMENDMENTS

12	Q	3242	3343	3452	3563	3678	3806	3970	4129
13	B	3198	3297	3402	3507	3620	3726	3903	4059
13	Q	3327	3429	3540	3649	3768	3880	4066	4230
14	B	3206	3306	3417	3522	3640	3765	3932	4088
14	Q	3332	3439	3553	3666	3792	3921	4098	4263
15	B	3276	3377	3489	3600	3721	3829	4016	4175
15	Q	3405	3512	3630	3749	3877	3987	4186	4354
16	B	3300	3421	3522	3638	3753	3869	4067	4231
16	Q	3433	3558	3666	3791	3909	4032	4246	4416
17	B	3303	3408	3522	3637	3762	3888	4083	4246
17	Q	3436	3545	3666	3790	3919	4053	4263	4433
18	B	3333	3440	3560	3677	3802	3930	4117	4279
18	Q	3470	3581	3706	3829	3962	4096	4296	4467
19	B	3380	3507	3621	3739	3862	3981	4192	4359
19	Q	3515	3649	3770	3896	4023	4150	4374	4550
20	B	3408	3533	3649	3776	3899	4026	4269	4441
20	Q	3545	3678	3803	3932	4064	4199	4460	4637
21	B	3505	3625	3739	3867	3997	4135	4361	4536
21	Q	3647	3776	3896	4028	4168	4317	4552	4735
22	B	3560	3691	3811	3954	4083	4234	4461	4638
22	Q	3706	3843	3970	4123	4263	4417	4658	4845
23	B	3644	3779	3910	4060	4198	4336	4574	4756
23	Q	3796	3937	4077	4234	4384	4526	4781	4969

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NOTICE OF ADOPTED AMENDMENTS

24	B	3651	3786	3922	4072	4219	4369	4603	4791
24	Q	3806	3944	4090	4249	4403	4568	4816	5010
25	B	3967	4126	4287	4472	4639	4823	5104	5307
25	Q	4136	4308	4477	4673	4851	5041	5335	5548
26	B	4127	4311	4489	4680	4866	5050	5347	5557
26	Q	4310	4497	4690	4890	5088	5275	5588	5812
27	B	4327	4514	4708	4903	5098	5287	5591	5814
27	Q	4522	4715	4923	5124	5324	5526	5838	6071

Effective May 20, 2013
Bargaining Unit: RC-009

Pay Grade	Pay Plan Code	S T E P S										
		1e	1b	1a	1	2	3	4	5	6	7	8
1	B	2476	2558	2639	2721	2783	2857	2924	2995	3066	3193	3320
1	Q	2573	2658	2743	2828	2891	2967	3042	3113	3185	3320	3455
2	B	2533	2616	2700	2783	2857	2934	2999	3082	3152	3285	3419
2	Q	2631	2718	2804	2891	2967	3046	3117	3205	3276	3416	3553
3	B	2552	2636	2720	2804	2891	2984	3076	3174	3276	3408	3546
3	Q	2650	2737	2825	2912	3004	3102	3199	3303	3405	3545	3687
4	B	2595	2681	2766	2852	2924	2998	3076	3157	3229	3366	3500
4	Q	2696	2785	2874	2963	3042	3116	3199	3281	3359	3501	3641
5	B	2614	2700	2786	2872	2961	3056	3152	3253	3357	3490	3632
5	Q	2719	2809	2898	2988	3078	3178	3276	3384	3489	3631	3777

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NOTICE OF ADOPTED AMENDMENTS

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
7	B	2729	2819	2909	2999	3091	3168	3261	3351	3438	3585	3728
7	Q	2836	2930	3023	3117	3212	3297	3394	3483	3578	3736	3885
8	B	2743	2833	2924	3014	3100	3191	3280	3368	3464	3621	3765
8	Q	2850	2944	3038	3132	3222	3318	3409	3504	3602	3770	3921
9	B	2754	2844	2935	3026	3120	3221	3321	3430	3542	3696	3843
9	Q	2864	2958	3053	3147	3246	3349	3457	3568	3689	3848	4002
10	B	2813	2906	2998	3091	3181	3271	3367	3460	3560	3725	3875
10	Q	2923	3019	3116	3212	3309	3400	3503	3597	3706	3879	4035
11	B	2821	2914	3007	3100	3198	3291	3395	3487	3586	3756	3907
11	Q	2932	3029	3125	3222	3327	3422	3533	3627	3737	3912	4070
12	B	2836	2929	3023	3116	3216	3318	3424	3533	3651	3811	3964
12	Q	2950	3047	3145	3242	3343	3452	3563	3678	3806	3970	4129
13	B	2910	3006	3102	3198	3297	3402	3507	3620	3726	3903	4059
13	Q	3028	3127	3227	3327	3429	3540	3649	3768	3880	4066	4230
14	B	2917	3014	3110	3206	3306	3417	3522	3640	3765	3932	4088
14	Q	3032	3132	3232	3332	3439	3553	3666	3792	3921	4098	4263
15	B	2981	3079	3178	3276	3377	3489	3600	3721	3829	4016	4175
15	Q	3099	3201	3303	3405	3512	3630	3749	3877	3987	4186	4354
16	B	3003	3102	3201	3300	3421	3522	3638	3753	3869	4067	4231
16	Q	3124	3227	3330	3433	3558	3666	3791	3909	4032	4246	4416

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NOTICE OF ADOPTED AMENDMENTS

17	B	3006	3105	3204	3303	3408	3522	3637	3762	3888	4083	4246
17	Q	3127	3230	3333	3436	3545	3666	3790	3919	4053	4263	4433
18	B	3033	3133	3233	3333	3440	3560	3677	3802	3930	4117	4279
18	Q	3158	3262	3366	3470	3581	3706	3829	3962	4096	4296	4467
19	B	3076	3177	3279	3380	3507	3621	3739	3862	3981	4192	4359
19	Q	3199	3304	3410	3515	3649	3770	3896	4023	4150	4374	4550
20	B	3101	3204	3306	3408	3533	3649	3776	3899	4026	4269	4441
20	Q	3226	3332	3439	3545	3678	3803	3932	4064	4199	4460	4637
21	B	3190	3295	3400	3505	3625	3739	3867	3997	4135	4361	4536
21	Q	3319	3428	3538	3647	3776	3896	4028	4168	4317	4552	4735
22	B	3240	3346	3453	3560	3691	3811	3954	4083	4234	4461	4638
22	Q	3372	3484	3595	3706	3843	3970	4123	4263	4417	4658	4845
23	B	3316	3425	3535	3644	3779	3910	4060	4198	4336	4574	4756
23	Q	3454	3568	3682	3796	3937	4077	4234	4384	4526	4781	4969
24	B	3322	3432	3541	3651	3786	3922	4072	4219	4369	4603	4791
24	Q	3463	3578	3692	3806	3944	4090	4249	4403	4568	4816	5010
25	B	3610	3729	3848	3967	4126	4287	4472	4639	4823	5104	5307
25	Q	3764	3888	4012	4136	4308	4477	4673	4851	5041	5335	5548
26	B	3756	3879	4003	4127	4311	4489	4680	4866	5050	5347	5557
26	Q	3922	4051	4181	4310	4497	4690	4890	5088	5275	5588	5812
27	B	3938	4067	4197	4327	4514	4708	4903	5098	5287	5591	5814
27	Q	4115	4251	4386	4522	4715	4923	5124	5324	5526	5838	6071

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Effective July 1, 2013
Bargaining Unit: RC-009

Pay Grade	Pay Plan Code	S T E P S										
		1e	1b	1a	1	2	3	4	5	6	7	8
1	B	2526	2609	2692	2775	2839	2914	2982	3055	3127	3257	3386
1	Q	2624	2711	2798	2885	2949	3026	3103	3175	3249	3386	3524
2	B	2584	2668	2754	2839	2914	2993	3059	3144	3215	3351	3487
2	Q	2684	2772	2860	2949	3026	3107	3179	3269	3342	3484	3624
3	B	2603	2689	2774	2860	2949	3044	3138	3237	3342	3476	3617
3	Q	2703	2792	2882	2970	3064	3164	3263	3369	3473	3616	3761
4	B	2647	2735	2821	2909	2982	3058	3138	3220	3294	3433	3570
4	Q	2750	2841	2931	3022	3103	3178	3263	3347	3426	3571	3714
5	B	2666	2754	2842	2929	3020	3117	3215	3318	3424	3560	3705
5	Q	2773	2865	2956	3048	3140	3242	3342	3452	3559	3704	3853
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
7	B	2784	2875	2967	3059	3153	3231	3326	3418	3507	3657	3803
7	Q	2893	2989	3083	3179	3276	3363	3462	3553	3650	3811	3963
8	B	2798	2890	2982	3074	3162	3255	3346	3435	3533	3693	3840
8	Q	2907	3003	3099	3195	3286	3384	3477	3574	3674	3845	3999
9	B	2809	2901	2994	3087	3182	3285	3387	3499	3613	3770	3920
9	Q	2921	3017	3114	3210	3311	3416	3526	3639	3763	3925	4082
10	B	2869	2964	3058	3153	3245	3336	3434	3529	3631	3800	3953

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10	Q	2981	3079	3178	3276	3375	3468	3573	3669	3780	3957	4116
11	B	2877	2972	3067	3162	3262	3357	3463	3557	3658	3831	3985
11	Q	2991	3090	3188	3286	3394	3490	3604	3700	3812	3990	4151
12	B	2893	2988	3083	3178	3280	3384	3492	3604	3724	3887	4043
12	Q	3009	3108	3208	3307	3410	3521	3634	3752	3882	4049	4212
13	B	2968	3066	3164	3262	3363	3470	3577	3692	3801	3981	4140
13	Q	3089	3190	3292	3394	3498	3611	3722	3843	3958	4147	4315
14	B	2975	3074	3172	3270	3372	3485	3592	3713	3840	4011	4170
14	Q	3093	3195	3297	3399	3508	3624	3739	3868	3999	4180	4348
15	B	3041	3141	3242	3342	3445	3559	3672	3795	3906	4096	4259
15	Q	3161	3265	3369	3473	3582	3703	3824	3955	4067	4270	4441
16	B	3063	3164	3265	3366	3489	3592	3711	3828	3946	4148	4316
16	Q	3186	3292	3397	3502	3629	3739	3867	3987	4113	4331	4504
17	B	3066	3167	3268	3369	3476	3592	3710	3837	3966	4165	4331
17	Q	3190	3295	3400	3505	3616	3739	3866	3997	4134	4348	4522
18	B	3094	3196	3298	3400	3509	3631	3751	3878	4009	4199	4365
18	Q	3221	3327	3433	3539	3653	3780	3906	4041	4178	4382	4556
19	B	3138	3241	3345	3448	3577	3693	3814	3939	4061	4276	4446
19	Q	3263	3370	3478	3585	3722	3845	3974	4103	4233	4461	4641
20	B	3163	3268	3372	3476	3604	3722	3852	3977	4107	4354	4530
20	Q	3291	3399	3508	3616	3752	3879	4011	4145	4283	4549	4730
21	B	3254	3361	3468	3575	3698	3814	3944	4077	4218	4448	4627
21	Q	3385	3497	3609	3720	3852	3974	4109	4251	4403	4643	4830

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NOTICE OF ADOPTED AMENDMENTS

22	B	3305	3413	3522	3631	3765	3887	4033	4165	4319	4550	4731
22	Q	3439	3554	3667	3780	3920	4049	4205	4348	4505	4751	4942
23	B	3382	3494	3606	3717	3855	3988	4141	4282	4423	4665	4851
23	Q	3523	3639	3756	3872	4016	4159	4319	4472	4617	4877	5068
24	B	3388	3501	3612	3724	3862	4000	4153	4303	4456	4695	4887
24	Q	3532	3650	3766	3882	4023	4172	4334	4491	4659	4912	5110
25	B	3682	3804	3925	4046	4209	4373	4561	4732	4919	5206	5413
25	Q	3839	3966	4092	4219	4394	4567	4766	4948	5142	5442	5659
26	B	3831	3957	4083	4210	4397	4579	4774	4963	5151	5454	5668
26	Q	4000	4132	4265	4396	4587	4784	4988	5190	5381	5700	5928
27	B	4017	4148	4281	4414	4604	4802	5001	5200	5393	5703	5930
27	Q	4197	4336	4474	4612	4809	5021	5226	5430	5637	5955	6192

Effective July 1, 2014
Bargaining Unit: RC-009

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
1	B	2577	2661	2746	2831	2896	2972	3042	3116	3190	3322	3454
1	Q	2676	2765	2854	2943	3008	3087	3165	3239	3314	3454	3594
2	B	2636	2721	2809	2896	2972	3053	3120	3207	3279	3418	3557
2	Q	2738	2827	2917	3008	3087	3169	3243	3334	3409	3554	3696
3	B	2655	2743	2829	2917	3008	3105	3201	3302	3409	3546	3689
3	Q	2757	2848	2940	3029	3125	3227	3328	3436	3542	3688	3836

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4	B	2700	2790	2877	2967	3042	3119	3201	3284	3360	3502	3641
4	Q	2805	2898	2990	3082	3165	3242	3328	3414	3495	3642	3788
5	B	2719	2809	2899	2988	3080	3179	3279	3384	3492	3631	3779
5	Q	2828	2922	3015	3109	3203	3307	3409	3521	3630	3778	3930
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
7	B	2840	2933	3026	3120	3216	3296	3393	3486	3577	3730	3879
7	Q	2951	3049	3145	3243	3342	3430	3531	3624	3723	3887	4042
8	B	2854	2948	3042	3135	3225	3320	3413	3504	3604	3767	3917
8	Q	2965	3063	3161	3259	3352	3452	3547	3645	3747	3922	4079
9	B	2865	2959	3054	3149	3246	3351	3455	3569	3685	3845	3998
9	Q	2979	3077	3176	3274	3377	3484	3597	3712	3838	4004	4164
10	B	2926	3023	3119	3216	3310	3403	3503	3600	3704	3876	4032
10	Q	3041	3141	3242	3342	3443	3537	3644	3742	3856	4036	4198
11	B	2935	3031	3128	3225	3327	3424	3532	3628	3731	3908	4065
11	Q	3051	3152	3252	3352	3462	3560	3676	3774	3888	4070	4234
12	B	2951	3048	3145	3242	3346	3452	3562	3676	3798	3965	4124
12	Q	3069	3170	3272	3373	3478	3591	3707	3827	3960	4130	4296
13	B	3027	3127	3227	3327	3430	3539	3649	3766	3877	4061	4223
13	Q	3151	3254	3358	3462	3568	3683	3796	3920	4037	4230	4401
14	B	3035	3135	3235	3335	3439	3555	3664	3787	3917	4091	4253
14	Q	3155	3259	3363	3467	3578	3696	3814	3945	4079	4264	4435

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

15	B	3102	3204	3307	3409	3514	3630	3745	3871	3984	4178	4344
15	Q	3224	3330	3436	3542	3654	3777	3900	4034	4148	4355	4530
16	B	3124	3227	3330	3433	3559	3664	3785	3905	4025	4231	4402
16	Q	3250	3358	3465	3572	3702	3814	3944	4067	4195	4418	4594
17	B	3127	3230	3333	3436	3546	3664	3784	3914	4045	4248	4418
17	Q	3254	3361	3468	3575	3688	3814	3943	4077	4217	4435	4612
18	B	3156	3260	3364	3468	3579	3704	3826	3956	4089	4283	4452
18	Q	3285	3394	3502	3610	3726	3856	3984	4122	4262	4470	4647
19	B	3201	3306	3412	3517	3649	3767	3890	4018	4142	4362	4535
19	Q	3328	3437	3548	3657	3796	3922	4053	4185	4318	4550	4734
20	B	3226	3333	3439	3546	3676	3796	3929	4057	4189	4441	4621
20	Q	3357	3467	3578	3688	3827	3957	4091	4228	4369	4640	4825
21	B	3319	3428	3537	3647	3772	3890	4023	4159	4302	4537	4720
21	Q	3453	3567	3681	3794	3929	4053	4191	4336	4491	4736	4927
22	B	3371	3481	3592	3704	3840	3965	4114	4248	4405	4641	4826
22	Q	3508	3625	3740	3856	3998	4130	4289	4435	4595	4846	5041
23	B	3450	3564	3678	3791	3932	4068	4224	4368	4511	4758	4948
23	Q	3593	3712	3831	3949	4096	4242	4405	4561	4709	4975	5169
24	B	3456	3571	3684	3798	3939	4080	4236	4389	4545	4789	4985
24	Q	3603	3723	3841	3960	4103	4255	4421	4581	4752	5010	5212
25	B	3756	3880	4004	4127	4293	4460	4652	4827	5017	5310	5521
25	Q	3916	4045	4174	4303	4482	4658	4861	5047	5245	5551	5772

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26	B	3908	4036	4165	4294	4485	4671	4869	5062	5254	5563	5781
26	Q	4080	4215	4350	4484	4679	4880	5088	5294	5489	5814	6047
27	B	4097	4231	4367	4502	4696	4898	5101	5304	5501	5817	6049
27	Q	4281	4423	4563	4704	4905	5121	5331	5539	5750	6074	6316

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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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

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Executive Secretary III	14033	RC-014	16
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
Human Resources Trainee (Department of Revenue)	19694	RC-014	07
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
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

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Property and Supply Clerk I	34791	RC-014	03.5
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

NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall

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NOTICE OF ADOPTED AMENDMENTS

have that percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours that would otherwise qualify them for premium pay under this provision.

RC-014-TR Clarification – 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).

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, the Step 8 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three 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 15 years of continuous service and have three 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 per month to \$100 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)

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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
04	Q	2891	2967	3046	3117	3205	3276	3416	3553
04	S	2961	3042	3118	3192	3278	3348	3487	3628

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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
10.5	B	3398	3507	3627	3738	3868	3981	4185	4353

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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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

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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	STEPS										
		1e	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

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3.5	B	2533	2616	2700	2783	2852	2924	2997	3066	3144	3276	3406
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

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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
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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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Bargaining Unit: RC-014

Pay Grade	Pay Plan Code	STEPS										
		1e	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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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

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NOTICE OF ADOPTED AMENDMENTS

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
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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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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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE K RC-023 (Registered Nurses, INA)**

Effective July 1, 2012
Bargaining Unit: RC-023

<u>Title</u>	<u>Title Code</u>	<u>Pay Plan Code</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>	<u>8</u>
Child Welfare Nurse Specialist	07197	B	5087	5326	5584	5838	6211	6427	6654	6918
Corrections Nurse I	09825	Q	4823	5046	5285	5512	5873	6080	6293	6544
Corrections Nurse I	09825	S	4873	5096	5335	5562	5923	6130	6343	6594
Corrections Nurse II	09826	Q	5421	5675	5946	6220	6615	6849	7088	7372
Corrections Nurse II	09826	S	5471	5725	5996	6270	6665	6899	7138	7422
Health Facilities Surveillance Nurse	18150	B	5087	5326	5584	5838	6211	6427	6654	6918
Nursing Act Assistant Coordinator	29731	B	5404	5680	5942	6213	6603	6832	7073	7355
Registered Nurse I (See Note)	38131	B	4527	4744	4961	5182	5511	5707	5906	6141
Registered Nurse I (See Note)	38131	Q	4593	4814	5032	5257	5592	5788	5991	6232
Registered Nurse II (See Note)	38132	B	5087	5326	5584	5838	6211	6427	6654	6918
Registered Nurse II (See Note)	38132	Q	5163	5404	5663	5922	6303	6524	6748	7020
Registered Nurse—Advanced Practice (See Note)	38135	B	5733	6028	6308	6596	7008	7251	7507	7808

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Registered Nurse— Advanced Practice (See Note)	38135	Q	5817	6118	6401	6694	7112	7360	7617	7925
Registered Nurse— Advanced Practice	38135	S	5867	6168	6451	6744	7162	7410	7667	7975

Effective July 1, 2013
Bargaining Unit: RC-023

<u>Title</u>	<u>Title Code</u>	<u>Pay Plan Code</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>	<u>8</u>
Child Welfare Nurse Specialist	07197	B	5189	5433	5696	5955	6335	6556	6787	7056
Corrections Nurse I	09825	Q	4919	5147	5391	5622	5990	6202	6419	6675
Corrections Nurse I	09825	S	4969	5197	5441	5672	6040	6252	6469	6725
Corrections Nurse II	09826	Q	5529	5789	6065	6344	6747	6986	7230	7519
Corrections Nurse II	09826	S	5579	5839	6115	6394	6797	7036	7280	7569
Health Facilities Surveillance Nurse	48150	B	5189	5433	5696	5955	6335	6556	6787	7056
Nursing Act Assistant Coordinator	29731	B	5512	5794	6061	6337	6735	6969	7214	7502
Registered Nurse I (See Note)	38131	B	4618	4839	5060	5286	5621	5821	6024	6264
Registered Nurse I (See Note)	38131	Q	4685	4910	5133	5362	5704	5904	6111	6357
Registered Nurse II (See Note)	38132	B	5189	5433	5696	5955	6335	6556	6787	7056
Registered Nurse II (See Note)	38132	Q	5266	5512	5776	6040	6429	6654	6883	7160
Registered Nurse— Advanced Practice (See Note)	38135	B	5848	6149	6434	6728	7148	7396	7657	7964

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Registered Nurse— Advanced Practice (See Note)	38135	Q	5933	6240	6529	6828	7254	7507	7769	8084
Registered Nurse— Advanced Practice	38135	S	5983	6290	6579	6878	7304	7557	7819	8134

**Effective July 1, 2014
Bargaining Unit: RC-023**

<u>Title</u>	<u>Title Code</u>	<u>Pay Plan Code</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>	<u>8</u>
Child Welfare Nurse Specialist	07197	B	5293	5542	5810	6074	6462	6687	6923	7197
Corrections Nurse I	09825	Q	5017	5250	5499	5734	6110	6326	6547	6809
Corrections Nurse I	09825	S	5067	5300	5549	5784	6160	6376	6597	6859
Corrections Nurse II	09826	Q	5640	5905	6186	6471	6882	7126	7375	7669
Corrections Nurse II	09826	S	5690	5955	6236	6521	6932	7176	7425	7719
Health Facilities Surveillance Nurse	18150	B	5293	5542	5810	6074	6462	6687	6923	7197
Nursing Act Assistant Coordinator	29731	B	5622	5910	6182	6464	6870	7108	7358	7652
Registered Nurse I (See Note)	38131	B	4710	4936	5161	5392	5733	5937	6144	6389
Registered Nurse I (See Note)	38131	Q	4779	5008	5236	5469	5818	6022	6233	6484
Registered Nurse II (See Note)	38132	B	5293	5542	5810	6074	6462	6687	6923	7197
Registered Nurse II (See Note)	38132	Q	5371	5622	5892	6161	6558	6787	7021	7303
Registered Nurse – Advanced Practice (See Note)	38135	B	5965	6272	6563	6863	7291	7544	7810	8123
Registered Nurse – Advanced Practice (See Note)	38135	Q	6052	6365	6660	6965	7399	7657	7924	8246

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Registered Nurse –

Advanced Practice 38135 S 6102 6415 6710 7015 7449 7707 7974 8296

NOTES: Shift Differential Pay – Shift Differential for bargaining unit employees shall be 10% of the employee's straight time hourly rate. Effective July 1, 2009, shift differential shall be 11% of the employee's straight time hourly rate. This payment shall be in addition to the employee's his/her base salary for all hours worked in a day if their regular schedule provides that the employee is scheduled to work half or more of the hours before 7:00 a.m. or after 3:00 p.m. Employees working schedules that qualify for shift differential shall receive shift differential for all paid time off, including use of accumulated compensatory time. Employees who work p.m. or night shifts shall be paid the differential provided they worked at least one-half or more of an evening or night shift regardless of regular schedule.

Longevity Pay – Effective July 1, 2010, the Step 8 rate shall be increased to \$50 per month for those employees who have three or more years of creditable service on Step 8 in the same pay grade. Effective July 1, 2010, the Step 8 rate shall be increased to \$75 per month for those employees who have six or more years of creditable service on Step 8 in the same pay grade. Effective July 1, 2013, the Step 8 rate shall be increased to \$75 per month for those employees who have three or more years of creditable service on Step 8 in the same pay grade. Effective July 1, 2013, the Step 8 rate shall be increased to \$100 per month for those employees who have six or more years of creditable service on Step 8 in the same pay grade.

Pension Formula – Effective January 1, 2011, employees newly hired into positions allocated to the Registered Nurse I, Registered Nurse II or Registered Nurse – Advanced Practice titles and outside of the Departments of Corrections and Juvenile Justice receive Pay Plan Code B rates. Employees newly hired are employees hired on or after January 1, 2011 who have 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 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).

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Uniform Allowance – All nurses who are in the Departments of Corrections and Veterans' Affairs, in certified status, and mandated to wear uniforms or scrubs, receive an annual reimbursement benefit of a maximum of \$450 effective July 1, 2011.

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

Section 310.APPENDIX A Negotiated Rates of Pay

Section 310.TABLE M RC-110 (Conservation Police Lodge)

<u>Title</u>	<u>Title Code</u>	<u>Pay Plan Code</u>
Conservation Police Officer I	09341	Q
Conservation Police Officer II	09342	Q
Conservation Police Officer Trainee	09345	Q

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 Officer I	4750	4976	5337	5588	5850	6127	6127
Conservation Police Officer II	0	0	5416	5669	5929	6207	6207
Conservation Police Officer Trainee	3810	3960					

Longevity Bonus Rates

~~Conservation Police Officer I~~

<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>
6419	6795	6963	6963	7041	7041	7041	7041	7041	7041

~~Conservation Police Officer II~~

<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>
6499	6876	7045	7045	7454	7800	8172	8250	8634	9036

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Effective January 1, 2012

<u>Title</u>	S T E P S						
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>
Conservation Police Officer I	4809	5038	5404	5658	5923	6204	6204
Conservation Police Officer II	0	0	5484	5740	6003	6285	6285
Conservation Police Officer Trainee	3858	4010					

Longevity Bonus Rates

Conservation Police Officer I

<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>
6499	6880	7050	7050	7154	7154	7154	7154	7154	7154

Conservation Police Officer II

<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>
6580	6962	7133	7133	7572	7923	8299	8378	8767	9174

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE N RC-010 (Professional Legal Unit, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>0</u>
Hearings Referee	18300	RC-010	23
Hearings Referee – Intermittent	18301	RC-010	23H
Public Service Administrator, Option 8L Departments of Central Management Services, Children and Family Services, Healthcare and Family Services, Labor, Public Health and Revenue, Environmental Protection Agency, Illinois Gaming Board, Guardianship and Advocacy Commission, and Pollution Control Board and administrative law judge function at the Departments of Healthcare and Family Services and Human Services	37015	RC-010	24
Senior Public Service Administrator, Option 8L Department of Revenue	40070	RC-010	26
Technical Advisor Advanced Program Specialist	45256	RC-010	24
Technical Advisor I	45251	RC-010	18
Technical Advisor II	45252	RC-010	20
Technical Advisor III	45253	RC-010	23

NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall have that percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours that would otherwise qualify them for premium pay under this provision.

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Option Clarification – The positions allocated to the Public Service Administrator title that are assigned to the negotiated RC-010 pay grade have the Option 8L. See the definition of option in Section 310.50.

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month.

Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by ~~\$75~~~~\$75.00~~ per month. Effective July 1, 2013, the Step 8 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three 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 15 years of continuous service and have three 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 per month to \$100 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,

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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-010~~

Pay Grade	Pay Plan Code	STEPS							
		1	2	3	4	5	6	7	8
18	B	4623	4845	5070	5302	5517	5739	6080	6325
18	Q	4828	5067	5301	5542	5768	5998	6358	6611
20	B	5146	5407	5657	5927	6185	6441	6832	7105
20	Q	5378	5649	5916	6197	6463	6731	7143	7428
23	B	6095	6418	6747	7067	7391	7712	8200	8528
23	Q	6373	6709	7052	7383	7727	8062	8566	8908
23H	B	37.51	39.50	41.52	43.49	45.48	47.46	50.46	52.48
24	B	6487	6831	7191	7533	7883	8237	8755	9104
24	Q	6780	7142	7513	7875	8234	8608	9149	9516
26	B	7377	7782	8196	8609	9011	9416	10023	10423
26	Q	7734	8153	8584	9018	9440	9861	10500	10920

~~Effective May 20, 2013~~
~~Bargaining Unit: RC-010~~

Pay Grade	Pay Plan Code	STEPS										
		1e	1b	1a	1	2	3	4	5	6	7	8
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

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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
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
23H	B	34.13	35.26	36.38	37.51	39.50	41.52	43.49	45.48	47.46	50.46	52.48
24	B	5903	6098	6292	6487	6831	7191	7533	7883	8237	8755	9104
24	Q	6170	6373	6577	6780	7142	7513	7875	8234	8608	9149	9516
26	B	6713	6934	7156	7377	7782	8196	8609	9011	9416	10023	10423
26	Q	7038	7270	7502	7734	8153	8584	9018	9440	9861	10500	10920

Effective July 1, 2013
Bargaining Unit: RC-010

Pay Grade	Pay Plan Code	S T E P S										
		1e	1b	1a	1	2	3	4	5	6	7	8
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
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
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
23H	B	34.81	35.96	37.11	38.26	40.28	42.35	44.36	46.39	48.41	51.47	53.53
24	B	6021	6220	6418	6617	6968	7335	7684	8041	8402	8930	9286
24	Q	6293	6500	6709	6916	7285	7663	8033	8399	8780	9332	9706
26	B	6847	7073	7299	7525	7938	8360	8781	9191	9604	10223	10631

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~~26 Q 7179 7415 7652 7889 8316 8756 9198 9629 10058 10710 11138~~

Effective July 1, 2014
Bargaining Unit: RC-010

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
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
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
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
23H	B	35.51	36.68	37.85	39.02	41.09	43.20	45.24	47.32	49.37	52.50	54.60
24	B	6141	6344	6546	6749	7107	7482	7838	8202	8570	9109	9472
24	Q	6419	6630	6843	7054	7431	7816	8194	8567	8956	9519	9900
26	B	6984	7214	7445	7676	8097	8527	8957	9375	9796	10427	10844
26	Q	7323	7563	7805	8047	8482	8931	9382	9822	10259	10924	11361

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE O RC-028 (Paraprofessional Human Services Employees, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Administrative Assistant I	00501	RC-028	17
Administrative Assistant II	00502	RC-028	19
Apparel/Dry Goods Specialist III	01233	RC-028	12.5
Assistant Reimbursement Officer	02424	RC-028	08
Capital Development Board Media Technician	06525	RC-028	14
Child Development Aide	07184	RC-028	10
Clinical Laboratory Associate	08200	RC-028	08
Clinical Laboratory Technician I	08215	RC-028	10
Clinical Laboratory Technician II	08216	RC-028	12
Compliance Officer	08919	RC-028	14
Construction Supervisor I	09561	RC-028	13
Construction Supervisor II	09562	RC-028	16
Crime Scene Investigator	09980	RC-028	21
Data Processing Administrative Specialist	11415	RC-028	14
Data Processing Specialist	11430	RC-028	12
Data Processing Technician	11440	RC-028	09
Data Processing Technician Trainee	11443	RC-028	06
Dental Assistant	11650	RC-028	10
Dental Hygienist	11700	RC-028	14
Electroencephalograph Technician	13300	RC-028	08
Environmental Equipment Operator I	13761	RC-028	12
Environmental Equipment Operator II	13762	RC-028	14
Environmental Protection Technician I	13831	RC-028	08
Environmental Protection Technician II	13832	RC-028	10
Guard Supervisor	17685	RC-028	14
Health Information Associate	18045	RC-028	10
Health Information Technician	18047	RC-028	12
Hearing & Speech Technician I	18261	RC-028	06
Hearing & Speech Technician II	18262	RC-028	09
Housekeeper II	19602	RC-028	03.5
Inhalation Therapist	21259	RC-028	08
Inhalation Therapy Supervisor	21260	RC-028	11

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Intermittent Unemployment Insurance Technician (Hourly)	21690	RC-028	06H
Laboratory Assistant	22995	RC-028	04
Laboratory Associate I	22997	RC-028	10
Laboratory Associate II	22998	RC-028	12
Legal Research Assistant	23350	RC-028	13
Licensed Practical Nurse I	23551	RC-028	10.5
Licensed Practical Nurse II	23552	RC-028	11.5
Lock and Dam Tender	24290	RC-028	10
Lottery Commodities Distributor II	24402	RC-028	12
Natural Resource Technician I	28851	RC-028	10
Natural Resource Technician II	28852	RC-028	13
Office Administrative Specialist	29990	RC-028	12
Office Administrator IV	29994	RC-028	14
Office Administrator V	29995	RC-028	15
Office Specialist	30080	RC-028	11
Pharmacy Lead Technician	32009	RC-028	09
Pharmacy Technician	32011	RC-028	07
Public Aid Eligibility Assistant	35825	RC-028	08
Radiologic Technologist	37500	RC-028	11
Radiologic Technologist Program Coordinator	37507	RC-028	12
Ranger	37725	RC-028	13
Rehabilitation Counselor Aide I	38155	RC-028	09
Rehabilitation Counselor Aide II	38156	RC-028	11
Senior Ranger	40090	RC-028	14
Site Interpreter	41090	RC-028	10
Site Technician I	41131	RC-028	10
Site Technician II	41132	RC-028	12
Social Service Community Planner	41295	RC-028	11
State Police Crime Information Evaluator	41801	RC-028	11
State Police Evidence Technician I	41901	RC-028	12
State Police Evidence Technician II	41902	RC-028	13
Statistical Research Technician	42748	RC-028	11
Veterans Service Officer	47800	RC-028	14
Vocational Instructor	48200	RC-028	12
Waterways Construction Supervisor I	49061	RC-028	16
Waterways Construction Supervisor II (Department of Natural Resources)	49062	RC-028	18

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NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall have that percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours that would otherwise qualify them for premium pay under this provision.

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, the Step 8 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three 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 15 years of continuous service and have three 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 per month to \$100 a month. Employees whose salaries are red-circled above the maximum Step rate

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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-028

Pay Grade	Pay Plan Code	S T E P S							
		1	2	3	4	5	6	7	8
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
04	Q	2891	2967	3046	3117	3205	3276	3416	3553
04	S	2961	3042	3118	3192	3278	3348	3487	3628
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
06H	B	18.09	18.55	19.05	19.58	20.07	20.64	21.51	22.36
06H	Q	18.77	19.27	19.81	20.36	20.89	21.45	22.36	23.26
06H	S	19.20	19.73	20.23	20.82	21.35	21.91	22.83	23.75
07	B	3014	3100	3191	3280	3368	3464	3621	3765
07	Q	3132	3222	3318	3409	3504	3602	3770	3921

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
09.5	B	3276	3377	3489	3600	3721	3829	4016	4175
09.5	Q	3405	3512	3630	3749	3877	3987	4186	4354
09.5	S	3479	3584	3707	3822	3953	4065	4267	4437
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
10.5	B	3408	3533	3649	3776	3899	4026	4269	4441
10.5	Q	3545	3678	3803	3932	4064	4199	4460	4637
10.5	S	3619	3753	3876	4008	4141	4278	4538	4720
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
11.5	B	3505	3625	3739	3867	3997	4135	4361	4536
11.5	Q	3647	3776	3896	4028	4168	4317	4552	4735
11.5	S	3718	3849	3971	4109	4250	4401	4640	4826
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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
21	B	5435	5715	5991	6270	6555	6829	7255	7544
21	Q	5680	5973	6260	6552	6852	7139	7582	7885

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

21 S 5764 6054 6341 6638 6935 7220 7666 7971

Effective May 20, 2013
Bargaining Unit: RC-028

Pay Grade	Pay Plan Code	STEPS										
		1e	1b	1a	1	2	3	4	5	6	7	8
3.5	B	2533	2616	2700	2783	2852	2924	2997	3066	3144	3276	3406
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
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
06H	B	16.46	17.00	17.54	18.09	18.55	19.05	19.58	20.07	20.64	21.51	22.36
06H	Q	17.08	17.64	18.21	18.77	19.27	19.81	20.36	20.89	21.45	22.36	23.26
06H	S	17.47	18.05	18.62	19.20	19.73	20.23	20.82	21.35	21.91	22.83	23.75
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

9	S	3090	3192	3294	3396	3500	3613	3724	3844	3956	4143	4310
9.5	B	2981	3079	3178	3276	3377	3489	3600	3721	3829	4016	4175
9.5	Q	3099	3201	3303	3405	3512	3630	3749	3877	3987	4186	4354
9.5	S	3166	3270	3375	3479	3584	3707	3822	3953	4065	4267	4437
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	3101	3204	3306	3408	3533	3649	3776	3899	4026	4269	4441
10.5	Q	3226	3332	3439	3545	3678	3803	3932	4064	4199	4460	4637
10.5	S	3293	3402	3510	3619	3753	3876	4008	4141	4278	4538	4720
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
11.5	B	3190	3295	3400	3505	3625	3739	3867	3997	4135	4361	4536
11.5	Q	3319	3428	3538	3647	3776	3896	4028	4168	4317	4552	4735
11.5	S	3383	3495	3606	3718	3849	3971	4109	4250	4401	4640	4826
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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
21	B	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

Effective July 1, 2013
Bargaining Unit: RC-028

Pay Grade	Pay Plan Code	STEPS										
		1e	1b	1a	1	2	3	4	5	6	7	8

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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
06H	B	16.78	17.34	17.90	18.45	18.92	19.43	19.97	20.47	21.05	21.94	22.81
06H	Q	17.43	17.99	18.57	19.14	19.66	20.20	20.77	21.31	21.88	22.81	23.73
06H	S	17.82	18.41	19.00	19.58	20.12	20.64	21.24	21.77	22.34	23.29	24.23
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
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
9.5	B	3041	3141	3242	3342	3445	3559	3672	3795	3906	4096	4259
9.5	Q	3161	3265	3369	3473	3582	3703	3824	3955	4067	4270	4441
9.5	S	3229	3335	3443	3549	3656	3781	3898	4032	4146	4352	4526
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

10	S	3253	3360	3467	3574	3702	3815	3941	4063	4196	4412	4587
10.5	B	3163	3268	3372	3476	3604	3722	3852	3977	4107	4354	4530
10.5	Q	3291	3399	3508	3616	3752	3879	4011	4145	4283	4549	4730
10.5	S	3359	3470	3580	3691	3828	3954	4088	4224	4364	4629	4814
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
11.5	B	3254	3361	3468	3575	3698	3814	3944	4077	4218	4448	4627
11.5	Q	3385	3497	3609	3720	3852	3974	4109	4251	4403	4643	4830
11.5	S	3451	3565	3678	3792	3926	4050	4191	4335	4489	4733	4923
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
21	B	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

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Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
06H	B	17.12	17.69	18.25	18.82	19.29	19.82	20.37	20.89	21.47	22.38	23.27
06H	Q	17.78	18.35	18.94	19.53	20.06	20.61	21.19	21.74	22.31	23.27	24.20
06H	S	18.18	18.78	19.38	19.98	20.52	21.05	21.66	22.21	22.79	23.75	24.71
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
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
9.5	B	3102	3204	3307	3409	3514	3630	3745	3871	3984	4178	4344
9.5	Q	3224	3330	3436	3542	3654	3777	3900	4034	4148	4355	4530
9.5	S	3294	3402	3512	3620	3729	3857	3976	4113	4229	4439	4617
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	3226	3333	3439	3546	3676	3796	3929	4057	4189	4441	4621
10.5	Q	3357	3467	3578	3688	3827	3957	4091	4228	4369	4640	4825
10.5	S	3426	3539	3652	3765	3905	4033	4170	4308	4451	4722	4910
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

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11	S	3436	3550	3663	3777	3910	4036	4181	4319	4456	4692	4879
11.5	B	3319	3428	3537	3647	3772	3890	4023	4159	4302	4537	4720
11.5	Q	3453	3567	3681	3794	3929	4053	4191	4336	4491	4736	4927
11.5	S	3520	3636	3752	3868	4005	4131	4275	4422	4579	4828	5021
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
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

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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
21	B	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

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE P RC-029 (Paraprofessional Investigatory and Law Enforcement Employees, IFPE)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Agricultural Products Promoter (See Note)	00815	RC-029	13
Animal and Animal Products Investigator	01072	RC-029	14
Apiary Inspector	01215	RC-029	04
Apiary Inspector (hourly)	01215	RC-029	04H
Arson Investigator I (See Note)	01481	RC-029	16
Arson Investigator II (See Note)	01482	RC-029	18
Arson Investigator II (Lead Worker) (See Note)	01482	RC-029	19
Breath Alcohol Analysis Technician (See Note)	05170	RC-029	16
Commerce Commission Police Officer I (See Note)	08451	RC-029	16
Commerce Commission Police Officer II (See Note)	08452	RC-029	18
Commodities Inspector	08770	RC-029	10
Drug Compliance Investigator	12778	RC-029	25
Elevator Inspector	13495	RC-029	18.5
Environmental Protection Legal Investigator I (See Note)	13811	RC-029	12
Environmental Protection Legal Investigator II	13812	RC-029	14
Environmental Protection Legal Investigator Specialist	13815	RC-029	15
Explosives Inspector I	14051	RC-029	14
Explosives Inspector II	14052	RC-029	17
Fingerprint Technician (See Note)	15204	RC-029	12
Fingerprint Technician Supervisor	15208	RC-029	17
Fire Prevention Inspector I	15316	RC-029	15
Fire Prevention Inspector II (See Note)	15317	RC-029	18
Fire Prevention Inspector Trainee (See Note)	15320	RC-029	12
Guard I	17681	RC-029	05
Guard II	17682	RC-029	08
Guard III	17683	RC-029	11
Licensing Assistant	23568	RC-029	07
Licensing Investigator I (See Note)	23571	RC-029	12
Licensing Investigator II	23572	RC-029	15
Licensing Investigator III (See Note)	23573	RC-029	16

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Licensing Investigator IV (See Note)	23574	RC-029	18
Liquor Control Special Agent I	23751	RC-029	15
Motorist Assistance Specialist	28490	RC-029	07
Plant and Pesticide Specialist I (See Note)	32501	RC-029	16
Plant and Pesticide Specialist II (See Note)	32502	RC-029	18
Plumbing Inspector (See Note)	32915	RC-029	19
Police Officer I (See Note)	32981	RC-029	16
Police Officer II (See Note)	32982	RC-029	18
Police Officer III (See Note)	32983	RC-029	20
Polygraph Examiner I (See Note)	33001	RC-029	18
Polygraph Examiner II (See Note)	33002	RC-029	20
Polygraph Examiner III (See Note)	33003	RC-029	22
Products and Standards Inspector	34603	RC-029	14
Security Officer (See Note)	39870	RC-029	12
Security Officer Sergeant (See Note)	39877	RC-029	13
Seed Analyst I	39951	RC-029	11
Seed Analyst II (See Note)	39952	RC-029	12
Site Security Officer	41115	RC-029	08
Truck Weighing Inspector (See Note)	46100	RC-029	12
Vehicle Compliance Inspector (See Note)	47570	RC-029	16
Vehicle Emissions Compliance Inspector (See Note)	47580	RC-029	12
Vehicle Emissions Quality Assurance Auditor (See Note)	47584	RC-029	13
Vital Records Quality Control Inspector (See Note)	48000	RC-029	12
Warehouse Claims Specialist (See Note)	48780	RC-029	19
Warehouse Examiner	48881	RC-029	15
Warehouse Examiner Specialist	48882	RC-029	17
Well Inspector I	49421	RC-029	14
Well Inspector II	49422	RC-029	17

NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.50 per hour in addition to their base salary rate for all hours worked if their regular schedule for that day excluding overtime provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. Employees in positions having an indeterminate work schedule are not eligible for shift differential. Effective July 1, 2003, employees shall be paid a shift differential of \$0.67 per hour in addition to their base salary based on the criteria in this Note. Effective January 1, 2009, employees shall be paid a shift differential of \$0.75 per hour in addition to their base salary based

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on the criteria in this Note. Effective July 1, 2009, employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary based on the criteria in this Note. Employees who currently receive a percentage shift differential providing more than the per hour based indicated in this Note on the base rate of pay prior to the effective date shall have that percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate.

Longevity Pay – Effective July 1, 1998, the Step 7 rate shall be increased by \$50 per month for those employees (non-sworn) who attain 15 years of service and have three or more years of creditable service on Step 7 in the same pay grade. Effective July 1, 2010, the Step 8 rate shall be increased \$50 per month for those employees (non-sworn) who attain 10 years of service and have three or more years of creditable service at Step 8 in the same pay grade. Effective July 1, 2010, the Step 8 rate shall be increased \$75 per month for those employees (non-sworn) who attain 15 years of service and have three or more years of creditable service on Step 8. Effective July 1, 2013, the Step 8 rate shall be increased \$75 per month for those employees (non-sworn) who attain 10 years of service and have three or more years of creditable service at Step 8 in the same pay grade. Effective July 1, 2013, the Step 8 rate shall be increased \$100 per month for those employees (non-sworn) who attain 15 years of service and have three or more years of creditable service on Step 8. Effective July 1, 1998, employees in the following classifications: Arson Investigator I and II; Commerce Commission Police Officer I and II; and Police Officer I, II and III. Effective July 1, 2003, employees in the following classification: Arson Investigator I and II; Commerce Commission Police Officer I and II; and Police Officer I, II and III shall be placed in a longevity schedule receiving a salary increase of \$50 per month upon reaching 10 years, 13 years, and 15 years of service in the same classification series. Employees shall be placed in a longevity schedule receiving a salary increase of \$75 per month upon reaching 17 years of service in the same classification series. Effective July 1, 2011, employees in the following classifications: Arson Investigator I and II; Commerce Commission Police Officer I and II; and Police Officer I, II and III shall be placed in a longevity schedule receiving a salary increase of \$50 per month upon reaching 10 years, 13 years, and 15 years of service in the same classification series. Employees shall be placed in a longevity schedule receiving a salary increase of \$100 per month upon reaching 17 years of service in the same classification series.

Pension Formula Change – 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

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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 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).

Effective July 1, 2012
Bargaining Unit: RC-029

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<u>8</u>
04	B	2857	2931	2998	3082	3151	3286	3339	3473
04-H	B	16.42							
05	B	2937	3011	3089	3165	3242	3377	3433	3572
07	B	3098	3189	3281	3366	3463	3621	3683	3832
08	B	3195	3291	3395	3486	3584	3755	3822	3976
10	B	3419	3520	3636	3750	3868	4065	4140	4306
11	B	3537	3651	3784	3906	4030	4241	4323	4497
12	B	3689	3810	3952	4081	4232	4459	4543	4723
12	Q	3841	3968	4121	4262	4417	4656	4751	4941
13	B	3828	3974	4122	4272	4433	4679	4771	4961
13	Q	3985	4143	4306	4463	4627	4890	4985	5186
14	B	3997	4153	4335	4492	4662	4934	5033	5236
15	B	4180	4352	4523	4707	4880	5176	5274	5486
16	B	4377	4572	4761	4961	5159	5463	5576	5799
16	Q	4777	4977	5183	5391	5712	5825	5944	6183
17	B	4592	4805	5008	5211	5422	5744	5862	6096
18	B	4843	5071	5299	5514	5737	6079	6199	6449
18	Q	5298	5539	5765	5994	6354	6480	6610	6874

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18.5	B	4869	5117	5359	5606	5844	6087	6458	6717
19	B	5117	5359	5606	5844	6087	6458	6583	6847
19	Q	5473	5715	5942	6171	6528	6654	6785	7056
20	B	5405	5656	5924	6184	6441	6829	6965	7242
20	Q	5648	5914	6193	6460	6730	7139	7278	7569
22	B	6043	6338	6637	6946	7232	7684	7837	8152
22	Q	6315	6627	6936	7257	7560	8030	8193	8520
25	B	6828	7188	7530	7878	8234	8750	8927	9284

Effective July 1, 2013
Bargaining Unit: RC-029

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>STEPS</u>										
		<u>1e</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>
04	B	2652	2739	2827	2914	2990	3058	3144	3214	3352	3406	3542
04-H	B	15.24	15.74	16.25	16.75							
05	B	2726	2816	2906	2996	3071	3151	3228	3307	3445	3502	3643
07	B	2876	2970	3065	3160	3253	3347	3433	3532	3693	3757	3909
08	B	2966	3063	3161	3259	3357	3463	3556	3656	3830	3898	4056
10	B	3173	3278	3382	3487	3590	3709	3825	3945	4146	4223	4392
11	B	3283	3392	3500	3608	3724	3860	3984	4111	4326	4409	4587
12	B	3424	3537	3650	3763	3886	4031	4163	4317	4548	4634	4817
12	Q	3565	3683	3800	3918	4047	4203	4347	4505	4749	4846	5040
13	B	3554	3671	3788	3905	4053	4204	4357	4522	4773	4866	5060
13	Q	3699	3821	3943	4065	4226	4392	4552	4720	4988	5085	5290
14	B	3710	3832	3955	4077	4236	4422	4582	4755	5033	5134	5341
15	B	3880	4008	4136	4264	4439	4613	4801	4978	5280	5379	5596
16	B	4063	4197	4331	4465	4663	4856	5060	5262	5572	5688	5915
16	Q	4434	4581	4727	4873	5077	5287	5499	5826	5942	6063	6307
17	B	4262	4403	4543	4684	4901	5108	5315	5530	5859	5979	6218
18	B	4495	4644	4792	4940	5172	5405	5624	5852	6201	6323	6578
18	Q	4918	5080	5242	5404	5650	5880	6114	6481	6610	6742	7011
18.5	B	4519	4668	4817	4966	5219	5466	5718	5961	6209	6587	6851
19	B	4749	4906	5062	5219	5466	5718	5961	6209	6587	6715	6984

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19	Q	5080	5247	5415	5582	5829	6061	6294	6659	6787	6921	7197
20	B	5017	5182	5348	5513	5769	6042	6308	6570	6966	7104	7387
20	Q	5243	5415	5588	5761	6032	6317	6589	6865	7282	7424	7720
22	B	5609	5794	5979	6164	6465	6770	7085	7377	7838	7994	8315
22	Q	5861	6055	6248	6441	6760	7075	7402	7711	8191	8357	8690
25	B	6338	6547	6756	6965	7332	7681	8036	8399	8925	9106	9470

Effective July 1, 2014
Bargaining Unit: RC-029

Pay Grade	Pay Plan Code	<u>STEPS</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>
04	B	2705	2794	2884	2972	3050	3119	3207	3278	3419	3474	3613
04-H	B	15.55	16.06	16.57	17.08							
05	B	2781	2872	2964	3056	3132	3214	3293	3373	3514	3572	3716
07	B	2934	3029	3126	3223	3318	3414	3502	3603	3767	3832	3987
08	B	3025	3124	3224	3324	3424	3532	3627	3729	3907	3976	4137
10	B	3236	3344	3450	3557	3662	3783	3902	4024	4229	4307	4480
11	B	3349	3460	3570	3680	3798	3937	4064	4193	4413	4497	4679
12	B	3492	3608	3723	3838	3964	4112	4246	4403	4639	4727	4913
12	Q	3636	3757	3876	3996	4128	4287	4434	4595	4844	4943	5141
13	B	3625	3744	3864	3983	4134	4288	4444	4612	4868	4963	5161
13	Q	3773	3897	4022	4146	4311	4480	4643	4814	5088	5187	5396
14	B	3784	3909	4034	4159	4321	4510	4674	4850	5134	5237	5448
15	B	3958	4088	4219	4349	4528	4705	4897	5078	5386	5487	5708
16	B	4144	4281	4418	4554	4756	4953	5161	5367	5683	5802	6033
16	Q	4523	4673	4822	4970	5179	5393	5609	5943	6061	6184	6433
17	B	4347	4491	4634	4778	4999	5210	5421	5641	5976	6099	6342
18	B	4585	4737	4888	5039	5275	5513	5736	5969	6325	6449	6710
18	Q	5016	5182	5347	5512	5763	5998	6236	6611	6742	6877	7151
18.5	B	4609	4761	4913	5065	5323	5575	5832	6080	6333	6719	6988
19	B	4844	5004	5163	5323	5575	5832	6080	6333	6719	6849	7124
19	Q	5182	5352	5523	5694	5946	6182	6420	6792	6923	7059	7341

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20	B	5117	5286	5455	5623	5884	6163	6434	6701	7105	7246	7535
20	Q	5348	5523	5700	5876	6153	6443	6721	7002	7428	7572	7874
22	B	5721	5910	6099	6287	6594	6905	7227	7525	7995	8154	8481
22	Q	5978	6176	6373	6570	6895	7217	7550	7865	8355	8524	8864
25	B	6465	6678	6891	7104	7479	7835	8197	8567	9104	9288	9659

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay

Section 310.TABLE Q RC-033 (Meat Inspectors, IFPE)

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Plan Code</u>
Meat and Poultry Inspector	26070	RC-033	B
Meat and Poultry Inspector Trainee	26075	RC-033	B

Effective July 1, 2012

Title	S T E P S							
	1	2	3	4	5	6	7	8
Meat and Poultry Inspector	3859	4027	4188	4347	4516	4769	4866	4915
Meat and Poultry Inspector Trainee	3273	3393	3522	3649	3777	3985	4063	4104

Effective May 1, 2013

Title	S T E P S										
	1e	1b	1a	1	2	3	4	5	6	7	8
Meat and Poultry Inspector	3512	3627	3743	3859	4027	4188	4347	4516	4769	4866	4915
Meat and Poultry Inspector Trainee	2978	3077	3175	3273	3393	3522	3649	3777	3985	4063	4104

Effective July 1, 2013

Title	S T E P S										
	1e	1b	1a	1	2	3	4	5	6	7	8
Meat and Poultry Inspector	3582	3700	3818	3936	4108	4272	4434	4606	4864	4963	5013
Meat and Poultry Inspector Trainee	3038	3139	3239	3338	3461	3592	3722	3853	4065	4144	4186

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Effective July 1, 2014

Title	S T E P S										
	1c	1b	1a	1	2	3	4	5	6	7	8
Meat and Poultry Inspector	3654	3774	3894	4015	4190	4357	4523	4698	4961	5062	5113
Meat and Poultry Inspector Trainee	3099	3202	3304	3405	3530	3664	3796	3930	4146	4227	4270

NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.50 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the hours before 8:00 a.m. or after 4:00 p.m. Effective July 1, 2009, shift differential shall be increased to \$0.80 per hour.

Pension Formula Change – 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 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).

Cook County Step Increase – Employees whose official work county is Cook County and are on Step 1 through 7 as of July 1, 2011, receive a one-time step increase to be effective July 1, 2011.

Longevity Pay – Employees who are eligible for longevity pay at Step 7 on or before July 1, 2007 shall continue to receive longevity pay after being placed on Step 8 while they remain in the same pay grade. For employees not eligible to receive longevity

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pay on or before July 1, 2007, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have 3 or more years of creditable service on Step 8 in the same pay grade. For those employees who attain 15 years of continuous service and have three or more years creditable service on Step 8 on the same pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2013, the Step 8 rate shall be increased by \$75 per month for those employees who attain 10 years continuous service and have three or more years of creditable service on Step 8 of the same pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on the same pay grade, the Step 8 rate shall be increased by \$100 per month.

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE R RC-042 (Residual Maintenance Workers, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Building/Grounds Laborer	05598	RC-042	01
Building/Grounds Lead I	05601	RC-042	04
Building/Grounds Lead II	05602	RC-042	05
Building/Grounds Maintenance Worker	05613	RC-042	02
Building/Grounds Supervisor	05605	RC-042	07
Intermittent Laborer (Maintenance) (Hourly)	21687	RC-042	01H
Race Track Maintainer I	37551	RC-042	03
Race Track Maintainer II	37552	RC-042	06
Refrigeration & Air Conditioning Repairer	38119	RC-042	07
Sign Shop Foreman	41000	RC-042	07

NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall have that percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours that would otherwise qualify them for premium pay under this provision.

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service

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on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, the Step 8 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three 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 15 years of continuous service and have three 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 per month to \$100 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-042~~

Pay Grade	Pay Plan Code	STEPS							
		1	2	3	4	5	6	7	8
01	B	3422	3538	3652	3785	3909	4031	4244	4414
01	Q	3560	3687	3807	3943	4075	4203	4431	4607
01	S	3630	3758	3879	4019	4151	4283	4510	4689

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01H	B	20.98	21.69	22.39	23.20	23.96	24.71	26.02	27.06
01H	Q	21.82	22.60	23.34	24.17	24.98	25.77	27.16	28.24
01H	S	22.25	23.04	23.78	24.64	25.45	26.26	27.65	28.74
02	B	3560	3691	3811	3954	4083	4234	4461	4638
02	Q	3706	3843	3970	4123	4263	4417	4658	4845
02	S	3778	3916	4044	4201	4344	4499	4741	4932
03	B	3694	3829	3975	4124	4274	4435	4681	4867
03	Q	3847	3987	4144	4307	4465	4629	4892	5088
03	S	3920	4065	4225	4389	4543	4712	4976	5175
04	B	3694	3829	3975	4124	4274	4435	4681	4867
04	Q	3847	3987	4144	4307	4465	4629	4892	5088
04	S	3920	4065	4225	4389	4543	4712	4976	5175
05	B	4005	4182	4354	4524	4708	4884	5178	5383
05	Q	4179	4362	4543	4727	4923	5104	5408	5626
05	S	4256	4443	4624	4810	5006	5186	5493	5712
06	B	4005	4182	4354	4524	4708	4884	5178	5383
06	Q	4179	4362	4543	4727	4923	5104	5408	5626
06	S	4256	4443	4624	4810	5006	5186	5493	5712
07	B	4005	4182	4354	4524	4708	4884	5178	5383
07	Q	4179	4362	4543	4727	4923	5104	5408	5626
07	S	4256	4443	4624	4810	5006	5186	5493	5712

Effective May 20, 2013
Bargaining Unit: RC-042

**Pay
Grade**

STEPS

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	Pay Plan Code	1e	1b	1a	1	2	3	4	5	6	7	8
	B	3114	3217	3319	3422	3538	3652	3785	3909	4031	4244	4414
	Q	3240	3346	3453	3560	3687	3807	3943	4075	4203	4431	4607
	S	3303	3412	3521	3630	3758	3879	4019	4151	4283	4510	4689
01H	B	19.09	19.72	20.35	20.98	21.69	22.39	23.20	23.96	24.71	26.02	27.06
01H	Q	19.86	20.51	21.17	21.82	22.60	23.34	24.17	24.98	25.77	27.16	28.24
01H	S	20.25	20.92	21.58	22.25	23.04	23.78	24.64	25.45	26.26	27.65	28.74
2	B	3240	3346	3453	3560	3691	3811	3954	4083	4234	4461	4638
2	Q	3372	3484	3595	3706	3843	3970	4123	4263	4417	4658	4845
2	S	3438	3551	3665	3778	3916	4044	4201	4344	4499	4741	4932
3	B	3362	3472	3583	3694	3829	3975	4124	4274	4435	4681	4867
3	Q	3501	3616	3732	3847	3987	4144	4307	4465	4629	4892	5088
3	S	3567	3685	3802	3920	4065	4225	4389	4543	4712	4976	5175
4	B	3362	3472	3583	3694	3829	3975	4124	4274	4435	4681	4867
4	Q	3501	3616	3732	3847	3987	4144	4307	4465	4629	4892	5088
4	S	3567	3685	3802	3920	4065	4225	4389	4543	4712	4976	5175
5	B	3645	3765	3885	4005	4182	4354	4524	4708	4884	5178	5383
5	Q	3803	3928	4054	4179	4362	4543	4727	4923	5104	5408	5626
5	S	3873	4001	4128	4256	4443	4624	4810	5006	5186	5493	5712
6	B	3645	3765	3885	4005	4182	4354	4524	4708	4884	5178	5383
6	Q	3803	3928	4054	4179	4362	4543	4727	4923	5104	5408	5626
6	S	3873	4001	4128	4256	4443	4624	4810	5006	5186	5493	5712
7	B	3645	3765	3885	4005	4182	4354	4524	4708	4884	5178	5383
7	Q	3803	3928	4054	4179	4362	4543	4727	4923	5104	5408	5626
7	S	3873	4001	4128	4256	4443	4624	4810	5006	5186	5493	5712

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Effective July 1, 2013
Bargaining Unit: RC-042

Pay Grade	Pay Plan Code	S T E P S										
		1e	1b	1a	1	2	3	4	5	6	7	8
1	B	3176	3281	3385	3490	3609	3725	3861	3987	4112	4329	4502
1	Q	3305	3413	3522	3631	3761	3883	4022	4157	4287	4520	4699
1	S	3369	3480	3591	3703	3833	3957	4099	4234	4369	4600	4783
01H	B	19.47	20.11	20.75	21.39	22.12	22.84	23.67	24.44	25.21	26.54	27.60
01H	Q	20.26	20.92	21.59	22.26	23.06	23.80	24.66	25.48	26.28	27.71	28.81
01H	S	20.65	21.33	22.01	22.70	23.50	24.26	25.13	25.96	26.78	28.20	29.32
2	B	3305	3413	3522	3631	3765	3887	4033	4165	4319	4550	4731
2	Q	3439	3554	3667	3780	3920	4049	4205	4348	4505	4751	4942
2	S	3507	3622	3738	3854	3994	4125	4285	4431	4589	4836	5031
3	B	3429	3541	3655	3768	3906	4055	4206	4359	4524	4775	4964
3	Q	3571	3688	3807	3924	4067	4227	4393	4554	4722	4990	5190
3	S	3638	3759	3878	3998	4146	4310	4477	4634	4806	5076	5279
4	B	3429	3541	3655	3768	3906	4055	4206	4359	4524	4775	4964
4	Q	3571	3688	3807	3924	4067	4227	4393	4554	4722	4990	5190
4	S	3638	3759	3878	3998	4146	4310	4477	4634	4806	5076	5279
5	B	3718	3840	3963	4085	4266	4441	4614	4802	4982	5282	5491
5	Q	3879	4007	4135	4263	4449	4634	4822	5021	5206	5516	5739
5	S	3950	4081	4211	4341	4532	4716	4906	5106	5290	5603	5826
6	B	3718	3840	3963	4085	4266	4441	4614	4802	4982	5282	5491
6	Q	3879	4007	4135	4263	4449	4634	4822	5021	5206	5516	5739
6	S	3950	4081	4211	4341	4532	4716	4906	5106	5290	5603	5826

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7	B	3718	3840	3963	4085	4266	4441	4614	4802	4982	5282	5491
7	Q	3879	4007	4135	4263	4449	4634	4822	5021	5206	5516	5739
7	S	3950	4081	4211	4341	4532	4716	4906	5106	5290	5603	5826

Effective July 1, 2014
Bargaining Unit: RC-042

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
1	B	3240	3347	3453	3560	3681	3800	3938	4067	4194	4416	4592
1	Q	3371	3481	3592	3704	3836	3961	4102	4240	4373	4610	4793
1	S	3436	3550	3663	3777	3910	4036	4181	4319	4456	4692	4879
01H	B	19.86	20.52	21.17	21.82	22.57	23.30	24.14	24.93	25.71	27.07	28.15
01H	Q	20.67	21.34	22.02	22.71	23.52	24.28	25.15	25.99	26.81	28.26	29.38
01H	S	21.06	21.76	22.46	23.15	23.97	24.74	25.63	26.48	27.32	28.76	29.91
2	B	3371	3481	3592	3704	3840	3965	4114	4248	4405	4641	4826
2	Q	3508	3625	3740	3856	3998	4130	4289	4435	4595	4846	5041
2	S	3577	3694	3813	3931	4074	4208	4371	4520	4681	4933	5132
3	B	3498	3612	3728	3843	3984	4136	4290	4446	4614	4871	5063
3	Q	3642	3762	3883	4002	4148	4312	4481	4645	4816	5090	5294
3	S	3711	3834	3956	4078	4229	4396	4567	4727	4902	5178	5385
4	B	3498	3612	3728	3843	3984	4136	4290	4446	4614	4871	5063
4	Q	3642	3762	3883	4002	4148	4312	4481	4645	4816	5090	5294
4	S	3711	3834	3956	4078	4229	4396	4567	4727	4902	5178	5385
5	B	3792	3917	4042	4167	4351	4530	4706	4898	5082	5388	5601
5	Q	3957	4087	4218	4348	4538	4727	4918	5121	5310	5626	5854

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5	S	4029	4163	4295	4428	4623	4810	5004	5208	5396	5715	5943
6	B	3792	3917	4042	4167	4351	4530	4706	4898	5082	5388	5601
6	Q	3957	4087	4218	4348	4538	4727	4918	5121	5310	5626	5854
6	S	4029	4163	4295	4428	4623	4810	5004	5208	5396	5715	5943
7	B	3792	3917	4042	4167	4351	4530	4706	4898	5082	5388	5601
7	Q	3957	4087	4218	4348	4538	4727	4918	5121	5310	5626	5854
7	S	4029	4163	4295	4428	4623	4810	5004	5208	5396	5715	5943

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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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)	37015	VR-704	24

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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and 8J (dietary manager function at Department of Corrections)			
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 – Hired before August 1, 2010 and on or after April 1, 2013 prior to December 31, 2014; all effective December 31, 2014	40800	VR-704	24
Shift Supervisor – Hired on or after August 1, 2010 through and including March 31, 2013 prior to December 31, 2014	40800	VR-704	23

NOTES: Shift Differential Pay – All Shift Supervisors shall conduct roll on scheduled work days and shall be compensated for 15 minutes for the roll call period at the appropriate rate. Unless specified below, Shift Supervisors shall receive ½ hour compensation for shift preparation at the appropriate rate. Those Shift Supervisors at facilities with 300 or more security staff shall receive 45 minutes preparation at the appropriate rate.

Option Clarification – 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.

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Longevity Pay – Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, an employee on Step 8, having 10 years of continuous service and three years creditable service at Step 8, shall be paid \$75 per month. An employee with 15 years continuous service and three years of creditable service at Step 8 shall receive 15 years continuous service and three years of creditable service at Step 8 shall receive \$100 per month.

Shift Supervisor – Pay Grade VR-704-23 is not assigned to the Shift Supervisor title effective December 31, 2014.

Hired Before or On March 31, 2013

~~Effective July 1, 2012~~
~~Bargaining Unit: VR-704~~

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<u>8</u>
23	Q	6438	6781	7134	7477	7819	8174	8688	9035
23	S	6519	6857	7211	7554	7901	8256	8765	9116
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

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26	Q	7729	8150	8581	9014	9435	9857	10496	10915
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27	B	7872	8300	8739	9181	9611	10042	10691	11119
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Effective July 1, 2013
Bargaining Unit: VR-704

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<u>8</u>
23	Q	6567	6917	7276	7627	7976	8337	8862	9215
23	S	6649	6994	7356	7705	8059	8421	8940	9299
24	B	6613	6964	7331	7680	8036	8398	8925	9281
24	Q	6913	7281	7659	8028	8396	8776	9328	9700
24	S	6999	7362	7743	8111	8483	8864	9411	9788
25	B	7049	7434	7825	8216	8607	8998	9576	9960
25	Q	7363	7768	8174	8589	8997	9404	10008	10409
25	S	7450	7855	8261	8671	9080	9486	10093	10498
26	B	7521	7933	8355	8777	9186	9598	10220	10627
26	Q	7884	8313	8753	9194	9624	10054	10706	11133
27	B	8029	8466	8914	9365	9803	10243	10905	11341

Effective July 1, 2014
Bargaining Unit: VR-704

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<u>8</u>
23	Q	6875	7241	7617	7984	8350	8728	9277	9647

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23	S	6961	7321	7701	8066	8437	8815	9359	9734
24	B	6745	7103	7478	7834	8197	8566	9104	9467
24	Q	7051	7427	7812	8189	8564	8952	9515	9894
24	S	7139	7509	7898	8273	8653	9041	9599	9984
25	B	7190	7583	7982	8380	8779	9178	9768	10159
25	Q	7510	7923	8337	8761	9177	9592	10208	10617
25	S	7599	8012	8426	8844	9262	9676	10295	10708
26	B	7671	8092	8522	8953	9370	9790	10424	10840
26	Q	8042	8479	8928	9378	9816	10255	10920	11356
27	B	8190	8635	9092	9552	9999	10448	11123	11568

Effective December 31, 2014
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>
24	B	6745	7103	7478	7834	8197	8566	9104	9467
24	Q	7051	7427	7812	8189	8564	8952	9515	9894
24	S	7139	7509	7898	8273	8653	9041	9599	9984
25	B	7190	7583	7982	8380	8779	9178	9768	10159
25	Q	7510	7923	8337	8761	9177	9592	10208	10617
25	S	7599	8012	8426	8844	9262	9676	10295	10708
26	B	7671	8092	8522	8953	9370	9790	10424	10840
26	Q	8042	8479	8928	9378	9816	10255	10920	11356
27	B	8190	8635	9092	9552	9999	10448	11123	11568

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Hired On or After April 1, 2013**Effective July 1, 2012
Bargaining Unit: VR-704**

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<u>8</u>
24	B	6159	6486	6828	7153	7484	7945	8575	9099
24	Q	6438	6781	7134	7477	7819	8303	8962	9510
24	S	6519	6857	7211	7554	7901	8386	9041	9596
25	B	6565	6924	7288	7652	8016	8513	9200	9765
25	Q	6858	7235	7613	8000	8380	8897	9616	10205
25	S	6939	7316	7694	8076	8457	8975	9697	10292
26	B	7005	7388	7781	8175	8556	9081	9820	10419
26	Q	7343	7743	8152	8563	8963	9512	10286	10915
27	B	7478	7885	8302	8722	9130	9691	10477	11119

**Effective July 1, 2013
Bargaining Unit: VR-704**

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<u>8</u>
24	B	6282	6616	6964	7296	7634	8104	8747	9281
24	Q	6567	6917	7276	7627	7976	8469	9141	9700
24	S	6649	6994	7356	7705	8059	8554	9223	9788
25	B	6697	7062	7434	7805	8177	8683	9384	9960
25	Q	6995	7380	7765	8160	8547	9075	9808	10409

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25	S	7078	7462	7848	8237	8626	9154	9891	10498
26	B	7145	7536	7937	8338	8727	9262	10016	10627
26	Q	7490	7897	8315	8734	9143	9702	10492	11133
27	B	7628	8043	8468	8897	9313	9884	10687	11341

Effective July 1, 2014
Bargaining Unit: VR-704

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<u>8</u>
24	B	6408	6748	7104	7442	7787	8266	8922	9467
24	Q	6698	7056	7421	7780	8136	8639	9325	9894
24	S	6782	7134	7503	7859	8220	8725	9407	9984
25	B	6831	7204	7583	7961	8340	8857	9573	10159
25	Q	7135	7527	7920	8323	8718	9256	10004	10617
25	S	7219	7611	8005	8402	8799	9337	10089	10708
26	B	7287	7687	8096	8505	8902	9447	10216	10840
26	Q	7640	8055	8482	8909	9325	9896	10702	11356
27	B	7781	8203	8637	9074	9499	10082	10901	11568

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE T HR-010 (Teachers of Deaf, IFT)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Plan Code</u>
Educator	13100	HR-010	N

~~Effective August 16, 2012~~
~~Bargaining Unit: HR-010~~

<u>Lane</u>	<u>Educational Level</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>	<u>8</u>
1	BA	3311	3494	3683	3867	4065	4255	4666	4853
2	BA + 8 Hours	3416	3599	3796	3993	4200	4398	4820	5013
3	BA + 16 Hours	3503	3710	3918	4122	4319	4536	4976	5175
4	BA + 24 Hours	3601	3819	4033	4246	4468	4679	5136	5344
5	MA	3712	3929	4149	4372	4600	4817	5287	5499
6	MA + 16 Hours	3799	4020	4240	4466	4696	4912	5389	5602
7	MA + 32 Hours	3915	4134	4359	4586	4816	5035	5520	5741

Effective August 16, 2013
Bargaining Unit: HR-010

<u>Lane</u>	<u>Educational Level</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>	<u>8</u>
1	BA	3377	3564	3757	3944	4146	4340	4759	4950
2	BA + 8 Hours	3484	3671	3872	4073	4284	4486	4916	5113
3	BA + 16 Hours	3573	3784	3996	4204	4405	4627	5076	5279
4	BA + 24 Hours	3673	3895	4114	4331	4557	4773	5239	5451
5	MA	3786	4008	4232	4459	4692	4913	5393	5609
6	MA + 16 Hours	3875	4100	4325	4555	4790	5010	5497	5714
7	MA + 32 Hours	3993	4217	4446	4678	4912	5136	5630	5856

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Effective August 16, 2014
Bargaining Unit: HR-010

<u>Lane</u>	<u>Educational Level</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>
1	BA	3135	3238	3342	3445	3635	3832	4023	4229	4427	4854	5049
2	BA + 8 Hours	3234	3341	3447	3554	3744	3949	4154	4370	4576	5014	5215
3	BA + 16 Hours	3316	3425	3535	3644	3860	4076	4288	4493	4720	5178	5385
4	BA + 24 Hours	3409	3521	3634	3746	3973	4196	4418	4648	4868	5344	5560
5	MA	3514	3630	3746	3862	4088	4317	4548	4786	5011	5501	5721
6	MA + 16 Hours	3597	3716	3834	3953	4182	4412	4646	4886	5110	5607	5828
7	MA + 32 Hours	3706	3829	3951	4073	4301	4535	4772	5010	5239	5743	5973

NOTESNOTE:

Bilingual Pay – For positions for which job descriptions require the use of sign language, or which require the employee to be bilingual, bilingual pay is paid on a percentage scale based on the sign communication proficiency interview (SCPI) test. An employee is paid the following percentage of the employee's monthly base salary depending on the skill level that the employee achieved on the SCPI test and paid monthly as bilingual pay in addition to the base salary:

1%	Survival
2%	Survival Plus
3%	Intermediate
4%	Intermediate Plus
5%	Advanced

Longevity Pay – Effective August 16, 2000, the Step 7 was increased by \$25 per month for the employees who attained 10 years of continuous service and have three or more years of creditable service on Step 7 in the same pay grade. Effective August 16, 2004, the Step 8 rate was increased by \$25 per month for the employees who attained 10 years of continuous service and have ~~three~~ 3-years or more years of creditable service on Step 8 in the same or higher pay grade. For the employees who attained 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, the Step 8 rate was raised by \$50

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per month. Longevity is paid each month per calendar year. Effective August 16, 2010, the Step 8 was raised by \$50 per month for the employees who attained 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 August 16, 2010. For the employees who attained 15 years of continuous service and have ~~three 3~~ or more years of creditable service on Step 7 in the same or higher pay grade on or before August 16, 2010, the Step 8 rate was increased by \$75 per month. Effective August 16, 2013, the Step 8 was raised by \$25 per month to \$75 per month for the employees who attained 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 August 16, 2013. For the employees who attained 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 August 16, 2013, the Step 8 rate was increased by \$25 per month to \$100 per month. Employees who are eligible for longevity 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. Employees not eligible for longevity pay on or before the date they are placed on Step 8 shall begin to receive longevity pay after ~~three 3~~ years or more of creditable service on Step 8.

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE V CU-500 (Corrections Meet and Confer Employees)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Correctional Casework Supervisor	09655	CU-500	20
Correctional Lieutenant	09673	CU-500	19
Corrections Clerk III	09773	CU-500	16
Corrections Food Service Supervisor III	09795	CU-500	18
Corrections Identification Supervisor	09800	CU-500	19
Corrections Industry Supervisor	09807	CU-500	18
Corrections Laundry Manager II	09809	CU-500	17
Corrections Leisure Activity Specialist IV	09814	CU-500	20
Corrections Maintenance Supervisor	09822	CU-500	17
Corrections Residence Counselor II	09838	CU-500	17
Corrections Supply Supervisor III	09863	CU-500	18
Juvenile Justice Supervisor	21980	CU-500	21
Juvenile Justice Youth and Family Specialist Supervisor	21995	CU-500	22
Property and Supply Clerk III	34793	CU-500	08
Public Service Administrator, Option 7	37015	CU-500	24
Storekeeper III	43053	CU-500	13

NOTES: Longevity Pay – Effective July 1, 2013 and 2014, the pay rates for all unit classifications and steps shall be increased by 2%. Effective July 1, 2013, the Step 8 rate shall be increased by \$25 per month to \$75 per month for those employees who attain 10 years of continuous service and three 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 15 years of continuous service and have three 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 per month to \$100 per month.

Shift Differential Pay – Employees shall be paid a shift differential of \$0.52 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7:00 a.m. or after 3:00 p.m. Effective January 1, 2009, employees shall be paid a shift differential of \$0.75 per hour in addition to their base salary based on the criteria in this Note. Effective July 1, 2009, employees shall be paid a shift

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differential of \$0.80 per hour in addition to their base salary based on the criteria in this Note. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated above based on the base rate of pay prior to the effective date shall have the percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. When, in past practice, the payment has been for all paid time, it shall continue as such. Such payment shall be for all paid time irrespective of the past practice. This shall not apply to employees who because of "flex time" scheduling made at their request are scheduled and work hours which would otherwise qualify them for premium pay.

Effective July 1, 2013
Bargaining Unit: CU-500

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>STEPS</u>										
		<u>1e</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>
08	Q				3363	3467	3569	3682	3781	3890	4068	4232
13	Q				4000	4149	4313	4479	4635	4808	5078	5281
16	Q				4550	4749	4962	5168	5374	5593	5910	6146
16	S				4631	4834	5047	5250	5460	5676	5997	6236
17	Q				4763	4986	5211	5426	5648	5872	6218	6464
17	S				4848	5070	5296	5512	5732	5953	6302	6554
18	Q				5009	5251	5492	5739	5970	6208	6570	6833
18	S				5099	5336	5578	5823	6057	6290	6657	6924
19	Q				5283	5547	5801	6070	6321	6583	6972	7251
19	S				5366	5627	5884	6155	6404	6667	7059	7342
20	Q				5576	5849	6120	6406	6678	6953	7368	7663

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20	S	5661	5937	6209	6494	6768	7037	7455	7754
21	Q	5879	6179	6468	6772	7075	7367	7820	8132
21	S	5967	6262	6557	6856	7162	7450	7905	8222
22	Q	6119	6435	6512	7059	7381	7687	8157	8480
22	S	6207	6514	6830	7140	7466	7772	8242	8570
24	Q	7004	7372	7749	8118	8487	8867	9419	9798
24	S	7087	7452	7834	8203	8572	8954	9504	9883

Effective October 9, 2013
Bargaining Unit: CU-500

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>STEPS</u>										
		<u>1e</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>
08	Q	3060	3161	3262	3363	3467	3569	3682	3781	3890	4068	4232
13	Q	3640	3760	3880	4000	4149	4313	4479	4635	4808	5078	5281
16	Q	4141	4277	4414	4550	4749	4962	5168	5374	5593	5910	6146
16	S	4214	4353	4492	4631	4834	5047	5250	5460	5676	5997	6236
17	Q	4334	4477	4620	4763	4986	5211	5426	5648	5872	6218	6464
17	S	4412	4557	4703	4848	5070	5296	5512	5732	5953	6302	6554
18	Q	4558	4708	4859	5009	5251	5492	5739	5970	6208	6570	6833
18	S	4640	4793	4946	5099	5336	5578	5823	6057	6290	6657	6924
19	Q	4808	4966	5125	5283	5547	5801	6070	6321	6583	6972	7251
19	S	4883	5044	5205	5366	5627	5884	6155	6404	6667	7059	7342

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20	Q	5074	5241	5409	5576	5849	6120	6406	6678	6953	7368	7663
20	S	5152	5321	5491	5661	5937	6209	6494	6768	7037	7455	7754
21	Q	5350	5526	5703	5879	6179	6468	6772	7075	7367	7820	8132
21	S	5430	5609	5788	5967	6262	6557	6856	7162	7450	7905	8222
22	Q	5568	5752	5935	6119	6435	6512	7059	7381	7687	8157	8480
22	S	5648	5835	6021	6207	6514	6830	7140	7466	7772	8242	8570
24	Q	6374	6584	6794	7004	7372	7749	8118	8487	8867	9419	9798
24	S	6449	6662	6874	7087	7452	7834	8203	8572	8954	9504	9883

Effective July 1, 2014
Bargaining Unit: CU-500

<u>Pay Grade</u>	<u>Pay Plan Code</u>	<u>STEPS</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>
08	Q	3121	3224	3327	3430	3536	3640	3756	3857	3968	4149	4317
13	Q	3713	3835	3958	4080	4232	4399	4569	4728	4904	5180	5387
16	Q	4224	4363	4502	4641	4844	5061	5271	5481	5705	6028	6269
16	S	4298	4440	4582	4724	4931	5148	5355	5569	5790	6117	6361
17	Q	4421	4567	4712	4858	5086	5315	5535	5761	5989	6342	6593
17	S	4500	4648	4797	4945	5171	5402	5622	5847	6072	6428	6685
18	Q	4649	4802	4956	5109	5356	5602	5854	6089	6332	6701	6970
18	S	4733	4889	5045	5201	5443	5690	5939	6178	6416	6790	7062
19	Q	4904	5065	5228	5389	5658	5917	6191	6447	6715	7111	7396
19	S	4981	5145	5309	5473	5740	6002	6278	6532	6800	7200	7489

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20	Q	5175	5346	5517	5688	5966	6242	6534	6812	7092	7515	7816
20	S	5255	5427	5601	5774	6056	6333	6624	6903	7178	7604	7909
21	Q	5457	5637	5817	5997	6303	6597	6907	7217	7514	7976	8295
21	S	5539	5721	5904	6086	6387	6688	6993	7305	7599	8063	8386
22	Q	5679	5867	6054	6241	6564	6642	7200	7529	7841	8320	8650
22	S	5761	5952	6141	6331	6644	6967	7283	7615	7927	8407	8741
24	Q	6501	6716	6930	7144	7519	7904	8280	8657	9044	9607	9994
24	S	6578	6795	7011	7229	7601	7991	8367	8743	9133	9694	10081

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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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

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Bank Examiner III	04133	RC-062	22
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
Cancer Registrar I	05951	RC-062	14
Cancer Registrar II	05952	RC-062	16
Cancer Registrar III	05953	RC-062	20
Cancer Registrar Assistant Manager	05954	RC-062	22
Cancer Registrar Manager	05955	RC-062	24
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

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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
Disability Appeals Officer	12530	RC-062	22
Disability Claims Adjudicator I	12537	RC-062	16

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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
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

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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
Human Rights Investigator III	19776	RC-062	19
Human Rights Mediator	19771	RC-062	17
Human Rights Specialist I	19778	RC-062	14

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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
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

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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
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

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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
Private Secretary I	34201	RC-062	16
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

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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, 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

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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
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

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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
Sex Offender Therapist I	40531	RC-062	17
Sex Offender Therapist II	40532	RC-062	19
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 Mine Inspector-at-Large	42240	RC-062	21
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

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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

NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall have that percentage converted to the cents per hour equivalent

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rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours that would otherwise qualify them for premium pay under this provision.

Option Clarification – 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.

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, the Step 8 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three 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 15 years of continuous service and have three 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 per month to \$100 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

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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.

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

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Revenue Auditor III, RC-062-26
 Revenue Auditor Trainee, RC-062-15
 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. This shall not apply to employees who are hired after April 1, 2013.

Effective July 1, 2012
Bargaining Unit: RC-062

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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

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	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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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

Pay Grade	Pay Plan Code	S T E P S										
		<u>1e</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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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
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

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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

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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

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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
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

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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
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

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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 38 Ill. Reg. 14818, effective July 1, 2014)

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Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE X RC-063 (Professional Employees, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Actuary III	00203	RC-063	26
Architect	01440	RC-063	22
Chaplain I	06901	RC-063	16
Chaplain II	06902	RC-063	19
Child Welfare Administrative Case Reviewer	07190	RC-063	22
Child Welfare Advanced Specialist	07215	RC-063	19
Child Welfare Court Facilitator	07196	RC-063	22
Child Welfare Senior Specialist	07217	RC-063	22
Child Welfare Specialist	07218	RC-063	18
Civil Engineer I	07601	RC-063	15
Civil Engineer II	07602	RC-063	17
Civil Engineer III	07603	RC-063	19
Civil Engineer IV	07604	RC-063	22
Clinical Pharmacist	08235	RC-063	25
Clinical Psychologist	08250	RC-063	23
Clinical Psychology Associate	08255	RC-063	18
Day Care Licensing Representative II	11472	RC-063	18
Dentist I	11751	RC-063	23
Dentist II	11752	RC-063	26
Electrical Engineer, Department of Public Health	13180	RC-063	22
Environmental Engineer I	13751	RC-063	15
Environmental Engineer II	13752	RC-063	17
Environmental Engineer III	13753	RC-063	19
Environmental Engineer IV	13754	RC-063	22
Environmental Protection Engineer I	13791	RC-063	15
Environmental Protection Engineer II	13792	RC-063	17
Environmental Protection Engineer III	13793	RC-063	19
Environmental Protection Engineer IV	13794	RC-063	22
Environmental Protection Geologist I	13801	RC-063	15
Environmental Protection Geologist II	13802	RC-063	17
Environmental Protection Geologist III	13803	RC-063	19

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Geographic Information Specialist I	17271	RC-063	19
Geographic Information Specialist II	17272	RC-063	23
Geographic Information Trainee	17276	RC-063	15
Graduate Pharmacist	17345	RC-063	20
Hearing and Speech Advanced Specialist	18227	RC-063	22
Hearing and Speech Associate	18231	RC-063	18
Hearing and Speech Specialist	18233	RC-063	20
Historical Library Chief of Acquisitions	16987	RC-063	19
Information Services Intern	21160	RC-063	15
Information Services Specialist I	21161	RC-063	17
Information Services Specialist II	21162	RC-063	19
Information Systems Analyst I	21165	RC-063	21
Information Systems Analyst II	21166	RC-063	23
Information Systems Analyst III	21167	RC-063	25
Laboratory Research Scientist	23025	RC-063	23
Landscape Architect	23145	RC-063	22
Landscape Planner	23150	RC-063	19
Librarian I	23401	RC-063	16
Librarian II	23402	RC-063	18
Management Systems Specialist	25583	RC-063	21
Manuscripts Manager, Historic Preservation Agency	25610	RC-063	19
Mechanical Engineer I	26201	RC-063	15
Mechanical Engineer II	26202	RC-063	17
Mechanical Engineer III	26203	RC-063	19
Nutritionist	29820	RC-063	18
Occupational Therapist	29900	RC-063	17
Occupational Therapist Program Coordinator	29908	RC-063	19
Occupational Therapist Supervisor	29910	RC-063	21
Optometrist	30300	RC-063	14
Pharmacy Services Coordinator	32010	RC-063	25
Physical Therapist	32145	RC-063	17
Physical Therapist Program Coordinator	32153	RC-063	19
Podiatrist	32960	RC-063	14
Project Designer	34725	RC-063	19
Psychologist I	35611	RC-063	17
Psychologist II	35612	RC-063	20

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Psychologist III	35613	RC-063	22
Psychologist Associate	35626	RC-063	15
Public Health Educator	36430	RC-063	19
Public Service Administrator, Option 8D	37015	RC-063	23
Public Service Administrator, Option 8P	37015	RC-063	26
Department of Human Services			
Public Service Administrator, Option 8U	37015	RC-063	21
Department of Human Services			
Public Service Administrator, Options 1, 3, 4, 6, 6E, 7 Criminal Justice Information Authority, 8A Department of Public Health, 8E, 8N, 8S Departments of Human Services and Veterans' Affairs and 8T	37015	RC-063	24
Public Service Administrator, Options 8H, 8I Department of Natural Resources and 9G	37015	RC-063	22
Rehabilitation/Mobility Instructor	38163	RC-063	19
Rehabilitation/Mobility Instructor Trainee	38167	RC-063	15
School Psychologist	39200	RC-063	19
Senior Public Service Administrator, Options 3, 4 Departments of Public Health, Human Services and Commerce and Economic Opportunity and Environmental Protection Agency, 8E and 8H	40070	RC-063	26
Senior Public Service Administrator, Option 8P	40070	RC-063	27
Social Worker II	41412	RC-063	19
Social Worker III	41413	RC-063	20
Social Worker IV	41414	RC-063	22
Staff Pharmacist	41787	RC-063	24
Statistical Research Supervisor	42745	RC-063	20
Veterinarian I	47901	RC-063	18
Veterinarian II	47902	RC-063	20
Veterinarian III	47903	RC-063	21
Vision/Hearing Consultant I	47941	RC-063	16
Vision/Hearing Consultant II	47942	RC-063	20

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Vision/Hearing Consultant III	47943	RC-063	21
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NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall have that percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours which would otherwise qualify them for premium pay under this provision.

Option Clarification – The positions allocated to the Public Service Administrator title that are assigned to the negotiated RC-063 pay grade have the following options: 1; 3; 4; 6; 6E; 7; 8A; 8D; 8E; 8H; 8I; 8N; 8P; 8S; 8T; 8U; and 9G. The positions allocated to the Senior Public Service Administrator title that are assigned to a negotiated pay grade have the Options 3, 8E, 8H and 8P. See the definition of option in Section 310.50.

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July

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1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, the Step 8 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three 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 15 years of continuous service and have three 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 per month to \$100 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.

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Pay Grade	Pay Plan Code	STEPS							
		1	2	3	4	5	6	7	8
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

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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	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	Q	5680	5973	6260	6552	6852	7139	7582	7885
21	S	5764	6054	6341	6638	6935	7220	7666	7971
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	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

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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	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	Q	8232	8680	9137	9604	10053	10504	11182	11630
28	B	8264	8711	9174	9639	10091	10543	11225	11676
29	B	8672	9143	9627	10115	10589	11064	11780	12250

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Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
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
17	B	3997	4128	4260	4392	4594	4805	5010	5213	5424	5747	5976

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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
21	B	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
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	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	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

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26	B	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	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	B	7892	8152	8412	8672	9143	9627	10115	10589	11064	11780	12250

Effective July 1, 2013
Bargaining Unit: RC-063

Pay Grade	Pay Plan Code	S T E P S										
		1e	1b	1a	1	2	3	4	5	6	7	8
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
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

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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
21	B	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
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	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	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

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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	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	B	8050	8315	8580	8845	9326	9820	10317	10801	11285	12016	12495

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Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
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
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

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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
21	B	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
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	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	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	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

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27	B	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	B	8211	8481	8752	9022	9513	10016	10523	11017	11511	12256	12745

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

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NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE Y RC-063 (Educator and Educator Trainees, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>
Educator	13100	RC-063
Educator Trainee	13148	RC-063

NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall have that percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours that would otherwise qualify them for premium pay under this provision.

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013,

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the Step 8 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three 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 15 years of continuous service and have three 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 per month to \$100 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.

Educator**Effective July 1, 2012**

12- Month Lane	Educational Level	Pay Plan Code	STEPS							
			1	2	3	4	5	6	7	8
1	BA	E	4487	4698	4903	5128	5392	5643	6122	6367
1	BA	L	4553	4763	4976	5207	5473	5726	6212	6460
1	BA	P	4633	4850	5056	5286	5554	5812	6294	6545
2	BA+8 Hours	E	4606	4820	5036	5301	5573	5836	6329	6584
2	BA+8 Hours	L	4677	4890	5109	5376	5652	5922	6424	6679
2	BA+8 Hours	P	4759	4975	5192	5461	5736	6005	6503	6763
3	BA+16 Hours	E	4716	4942	5194	5469	5732	6023	6533	6793
3	BA+16 Hours	L	4785	5014	5269	5549	5817	6111	6628	6893
3	BA+16 Hours	P	4867	5096	5353	5632	5900	6197	6711	6980
4	BA+24 Hours	E	4824	5066	5351	5633	5923	6209	6747	7017
4	BA+24 Hours	L	4895	5141	5429	5716	6012	6300	6843	7120

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4	BA+24 Hours	P	4980	5222	5512	5796	6097	6383	6932	7208
5	MA	E	4948	5210	5508	5801	6107	6391	6949	7228
5	MA	L	5019	5286	5587	5885	6195	6492	7052	7336
5	MA	P	5104	5368	5669	5966	6277	6574	7135	7421
6	MA+16 Hours	E	5037	5333	5626	5922	6228	6520	7090	7373
6	MA+16 Hours	L	5111	5408	5708	6007	6324	6615	7195	7481
6	MA+16 Hours	P	5193	5493	5790	6096	6405	6702	7273	7565
7	MA+32 Hours	E	5192	5483	5786	6087	6388	6686	7261	7551
7	MA+32 Hours	L	5268	5565	5870	6178	6487	6784	7364	7660
7	MA+32 Hours	P	5352	5647	5955	6260	6572	6867	7450	7748

Effective May 20, 2013

12- Month Lane	Educational Level	Pay Plan Code	STEPS										
			1e	1b	1a	1	2	3	4	5	6	7	8
1	BA	E	4083	4218	4352	4487	4698	4903	5128	5392	5643	6122	6367
1	BA	L	4143	4280	4416	4553	4763	4976	5207	5473	5726	6212	6460
1	BA	P	4216	4355	4494	4633	4850	5056	5286	5554	5812	6294	6545
2	BA+8 Hours	E	4191	4330	4468	4606	4820	5036	5301	5573	5836	6329	6584
2	BA+8 Hours	L	4256	4396	4537	4677	4890	5109	5376	5652	5922	6424	6679
2	BA+8 Hours	P	4331	4473	4616	4759	4975	5192	5461	5736	6005	6503	6763
3	BA+16 Hours	E	4292	4433	4575	4716	4942	5194	5469	5732	6023	6533	6793
3	BA+16 Hours	L	4354	4498	4641	4785	5014	5269	5549	5817	6111	6628	6893
3	BA+16 Hours	P	4429	4575	4721	4867	5096	5353	5632	5900	6197	6711	6980
4	BA+24 Hours	E	4390	4535	4679	4824	5066	5351	5633	5923	6209	6747	7017
4	BA+24 Hours	L	4454	4601	4748	4895	5141	5429	5716	6012	6300	6843	7120
4	BA+24 Hours	P	4532	4681	4831	4980	5222	5512	5796	6097	6383	6932	7208
5	MA	E	4503	4651	4800	4948	5210	5508	5801	6107	6391	6949	7228
5	MA	L	4567	4718	4868	5019	5286	5587	5885	6195	6492	7052	7336
5	MA	P	4645	4798	4951	5104	5368	5669	5966	6277	6574	7135	7421
6	MA+16 Hours	E	4584	4735	4886	5037	5333	5626	5922	6228	6520	7090	7373
6	MA+16 Hours	L	4651	4804	4958	5111	5408	5708	6007	6324	6615	7195	7481

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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6	MA + 16 Hours	P	4726	4881	5037	5193	5493	5790	6096	6405	6702	7273	7565
7	MA + 32 Hours	E	4725	4880	5036	5192	5483	5786	6087	6388	6686	7261	7551
7	MA + 32 Hours	L	4794	4952	5110	5268	5565	5870	6178	6487	6784	7364	7660
7	MA + 32 Hours	P	4870	5031	5191	5352	5647	5955	6260	6572	6867	7450	7748

Effective July 1, 2013

12- Month Lane	Educational Level	Pay Plan Code	S T E P S										
			1e	1b	1a	1	2	3	4	5	6	7	8
1	BA	E	4165	4302	4439	4577	4792	5001	5231	5500	5756	6244	6494
1	BA	L	4226	4366	4504	4644	4858	5076	5311	5582	5841	6336	6589
1	BA	P	4300	4442	4584	4726	4947	5157	5392	5665	5928	6420	6676
2	BA + 8 Hours	E	4275	4417	4557	4698	4916	5137	5407	5684	5953	6456	6716
2	BA + 8 Hours	L	4341	4484	4628	4771	4988	5211	5484	5765	6040	6552	6813
2	BA + 8 Hours	P	4418	4562	4708	4854	5075	5296	5570	5851	6125	6633	6898
3	BA + 16 Hours	E	4378	4522	4667	4810	5041	5298	5578	5847	6143	6664	6929
3	BA + 16 Hours	L	4441	4588	4734	4881	5114	5374	5660	5933	6233	6761	7031
3	BA + 16 Hours	P	4518	4667	4815	4964	5198	5460	5745	6018	6321	6845	7120
4	BA + 24 Hours	E	4478	4626	4773	4920	5167	5458	5746	6041	6333	6882	7157
4	BA + 24 Hours	L	4543	4693	4843	4993	5244	5538	5830	6132	6426	6980	7262
4	BA + 24 Hours	P	4623	4775	4928	5080	5326	5622	5912	6219	6511	7071	7352
5	MA	E	4593	4744	4896	5047	5314	5618	5917	6229	6519	7088	7373
5	MA	L	4658	4812	4965	5119	5392	5699	6003	6319	6622	7193	7483
5	MA	P	4738	4894	5050	5206	5475	5782	6085	6403	6705	7278	7569
6	MA + 16 Hours	E	4676	4830	4984	5138	5440	5739	6040	6353	6650	7232	7520
6	MA + 16 Hours	L	4744	4900	5057	5213	5516	5822	6127	6450	6747	7339	7631
6	MA + 16 Hours	P	4821	4979	5138	5297	5603	5906	6218	6533	6836	7418	7716
7	MA + 32 Hours	E	4820	4978	5137	5296	5593	5902	6209	6516	6820	7406	7702
7	MA + 32 Hours	L	4890	5051	5212	5373	5676	5987	6302	6617	6920	7511	7813
7	MA + 32 Hours	P	4967	5132	5295	5459	5760	6074	6385	6703	7004	7599	7903

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Effective July 1, 2014

12- Month Lane	Educational Level	Pay Plan Code	S T E P S										
			1c	1b	1a	1	2	3	4	5	6	7	8
1	BA	E	4248	4388	4528	4669	4888	5101	5336	5610	5871	6369	6624
1	BA	L	4311	4453	4594	4737	4955	5178	5417	5694	5958	6463	6721
1	BA	P	4386	4531	4676	4821	5046	5260	5500	5778	6047	6548	6810
2	BA + 8 Hours	E	4361	4505	4648	4792	5014	5240	5515	5798	6072	6585	6850
2	BA + 8 Hours	L	4428	4574	4721	4866	5088	5315	5594	5880	6161	6683	6949
2	BA + 8 Hours	P	4506	4653	4802	4951	5177	5402	5681	5968	6248	6766	7036
3	BA + 16 Hours	E	4466	4612	4760	4906	5142	5404	5690	5964	6266	6797	7068
3	BA + 16 Hours	L	4530	4680	4829	4979	5216	5481	5773	6052	6358	6896	7172
3	BA + 16 Hours	P	4608	4760	4911	5063	5302	5569	5860	6138	6447	6982	7262
4	BA + 24 Hours	E	4568	4719	4868	5018	5270	5567	5861	6162	6460	7020	7300
4	BA + 24 Hours	L	4634	4787	4940	5093	5349	5649	5947	6255	6555	7120	7407
4	BA + 24 Hours	P	4715	4871	5027	5182	5433	5734	6030	6343	6641	7212	7499
5	MA	E	4685	4839	4994	5148	5420	5730	6035	6354	6649	7230	7520
5	MA	L	4751	4908	5064	5221	5500	5813	6123	6445	6754	7337	7633
5	MA	P	4833	4992	5151	5310	5585	5898	6207	6531	6839	7424	7720
6	MA + 16 Hours	E	4770	4927	5084	5241	5549	5854	6161	6480	6783	7377	7670
6	MA + 16 Hours	L	4839	4998	5158	5317	5626	5938	6250	6579	6882	7486	7784
6	MA + 16 Hours	P	4917	5079	5241	5403	5715	6024	6342	6664	6973	7566	7870
7	MA + 32 Hours	E	4916	5078	5240	5402	5705	6020	6333	6646	6956	7554	7856
7	MA + 32 Hours	L	4988	5152	5316	5480	5790	6107	6428	6749	7058	7661	7969
7	MA + 32 Hours	P	5066	5235	5401	5568	5875	6195	6513	6837	7144	7751	8061

Effective July 1, 2012

9- Month Lane	Educational Level	Pay Plan Code	S T E P S							
			1	2	3	4	5	6	7	8
†	BA	M	3313	3495	3686	3868	4067	4256	4670	4855
†	BA	Θ	3313	3495	3686	3868	4067	4256	4670	4855

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

2	BA+8 Hours	M	3417	3601	3798	3994	4201	4401	4822	5015
2	BA+8 Hours	Ø	3417	3601	3798	3994	4201	4401	4822	5015
3	BA+16 Hours	M	3505	3711	3919	4124	4321	4538	4979	5178
3	BA+16 Hours	Ø	3505	3711	3919	4124	4321	4538	4979	5178
4	BA+24 Hours	M	3603	3821	4035	4248	4470	4682	5139	5347
4	BA+24 Hours	Ø	3603	3821	4035	4248	4470	4682	5139	5347
5	MA	M	3714	3931	4150	4374	4601	4820	5289	5502
5	MA	Ø	3714	3931	4150	4374	4601	4820	5289	5502
6	MA+16 Hours	M	3802	4022	4243	4468	4698	4912	5391	5605
6	MA+16 Hours	Ø	3802	4022	4243	4468	4698	4912	5391	5605
7	MA+32 Hours	M	3917	4137	4361	4588	4817	5038	5522	5744
7	MA+32 Hours	Ø	3917	4137	4361	4588	4817	5038	5522	5744

Effective May 20, 2013

9-Month Lane	Educational Level	Pay Plan Code	STEPS										
			1e	1b	1a	1	2	3	4	5	6	7	8
1	BA	M	3015	3114	3214	3313	3495	3686	3868	4067	4256	4670	4855
1	BA	Ø	3015	3114	3214	3313	3495	3686	3868	4067	4256	4670	4855
2	BA+8 Hours	M	3109	3212	3314	3417	3601	3798	3994	4201	4401	4822	5015
2	BA+8 Hours	Ø	3109	3212	3314	3417	3601	3798	3994	4201	4401	4822	5015
3	BA+16 Hours	M	3190	3295	3400	3505	3711	3919	4124	4321	4538	4979	5178
3	BA+16 Hours	Ø	3190	3295	3400	3505	3711	3919	4124	4321	4538	4979	5178
4	BA+24 Hours	M	3279	3387	3495	3603	3821	4035	4248	4470	4682	5139	5347
4	BA+24 Hours	Ø	3279	3387	3495	3603	3821	4035	4248	4470	4682	5139	5347
5	MA	M	3380	3491	3603	3714	3931	4150	4374	4601	4820	5289	5502
5	MA	Ø	3380	3491	3603	3714	3931	4150	4374	4601	4820	5289	5502
6	MA+16 Hours	M	3460	3574	3688	3802	4022	4243	4468	4698	4912	5391	5605
6	MA+16 Hours	Ø	3460	3574	3688	3802	4022	4243	4468	4698	4912	5391	5605
7	MA+32 Hours	M	3564	3682	3799	3917	4137	4361	4588	4817	5038	5522	5744
7	MA+32 Hours	Ø	3564	3682	3799	3917	4137	4361	4588	4817	5038	5522	5744

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Effective July 1, 2013

9- Month Lane	Educational Level	Pay Plan Code	S T E P S										
			1e	1b	1a	1	2	3	4	5	6	7	8
1	BA	M	3075	3176	3278	3379	3565	3760	3945	4148	4341	4763	4952
1	BA	O	3075	3176	3278	3379	3565	3760	3945	4148	4341	4763	4952
2	BA + 8 Hours	M	3171	3276	3380	3485	3673	3874	4074	4285	4489	4918	5115
2	BA + 8 Hours	O	3171	3276	3380	3485	3673	3874	4074	4285	4489	4918	5115
3	BA + 16 Hours	M	3254	3361	3468	3575	3785	3997	4206	4407	4629	5079	5282
3	BA + 16 Hours	O	3254	3361	3468	3575	3785	3997	4206	4407	4629	5079	5282
4	BA + 24 Hours	M	3345	3455	3565	3675	3897	4116	4333	4559	4776	5242	5454
4	BA + 24 Hours	O	3345	3455	3565	3675	3897	4116	4333	4559	4776	5242	5454
5	MA	M	3448	3561	3675	3788	4010	4233	4461	4693	4916	5395	5612
5	MA	O	3448	3561	3675	3788	4010	4233	4461	4693	4916	5395	5612
6	MA + 16 Hours	M	3529	3645	3762	3878	4102	4328	4557	4792	5010	5499	5717
6	MA + 16 Hours	O	3529	3645	3762	3878	4102	4328	4557	4792	5010	5499	5717
7	MA + 32 Hours	M	3635	3756	3875	3995	4220	4448	4680	4913	5139	5632	5859
7	MA + 32 Hours	O	3635	3756	3875	3995	4220	4448	4680	4913	5139	5632	5859

Effective July 1, 2014

9- Month Lane	Educational Level	Pay Plan Code	S T E P S										
			1c	1b	1a	1	2	3	4	5	6	7	8
1	BA	M	3137	3240	3344	3447	3636	3835	4024	4231	4428	4858	5051
1	BA	O	3137	3240	3344	3447	3636	3835	4024	4231	4428	4858	5051
2	BA + 8 Hours	M	3234	3342	3448	3555	3746	3951	4155	4371	4579	5016	5217
2	BA + 8 Hours	O	3234	3342	3448	3555	3746	3951	4155	4371	4579	5016	5217
3	BA + 16 Hours	M	3319	3428	3537	3647	3861	4077	4290	4495	4722	5181	5388
3	BA + 16 Hours	O	3319	3428	3537	3647	3861	4077	4290	4495	4722	5181	5388
4	BA + 24 Hours	M	3412	3524	3636	3749	3975	4198	4420	4650	4872	5347	5563
4	BA + 24 Hours	O	3412	3524	3636	3749	3975	4198	4420	4650	4872	5347	5563

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

5	MA	M	3517	3632	3749	3864	4090	4318	4550	4787	5014	5503	5724
5	MA	O	3517	3632	3749	3864	4090	4318	4550	4787	5014	5503	5724
6	MA + 16 Hours	M	3600	3718	3837	3956	4184	4415	4648	4888	5110	5609	5831
6	MA + 16 Hours	O	3600	3718	3837	3956	4184	4415	4648	4888	5110	5609	5831
7	MA + 32 Hours	M	3708	3831	3953	4075	4304	4537	4774	5011	5242	5745	5976
7	MA + 32 Hours	O	3708	3831	3953	4075	4304	4537	4774	5011	5242	5745	5976

Educator Trainee**~~Effective August 11, 2011~~**

12-Month Lane	Educational Level	Pay Plan Code	Rate
1	BA	E	3981
1	BA	L	4040
1	BA	P	4113
2	BA + 8 Hours	E	3981
2	BA + 8 Hours	L	4040
2	BA + 8 Hours	P	4113
3	BA + 16 Hours	E	4087
3	BA + 16 Hours	L	4125
3	BA + 16 Hours	P	4219
4	BA + 24 Hours	E	4180
4	BA + 24 Hours	L	4239
4	BA + 24 Hours	P	4314
5	MA	E	4274
5	MA	L	4338
5	MA	P	4413
6	MA + 16 Hours	E	4384
6	MA + 16 Hours	L	4447
6	MA + 16 Hours	P	4526
7	MA + 32 Hours	E	4463
7	MA + 32 Hours	L	4530

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

7	MA + 32 Hours	P	4604
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Effective January 1, 2012

12-Month Lane	Educational Level	Pay Plan Code	Rate
1	BA	E	4031
1	BA	L	4091
1	BA	P	4164
2	BA + 8 Hours	E	4031
2	BA + 8 Hours	L	4091
2	BA + 8 Hours	P	4164
3	BA + 16 Hours	E	4138
3	BA + 16 Hours	L	4197
3	BA + 16 Hours	P	4272
4	BA + 24 Hours	E	4232
4	BA + 24 Hours	L	4292
4	BA + 24 Hours	P	4368
5	MA	E	4327
5	MA	L	4392
5	MA	P	4468
6	MA + 16 Hours	E	4439
6	MA + 16 Hours	L	4503
6	MA + 16 Hours	P	4583
7	MA + 32 Hours	E	4519
7	MA + 32 Hours	L	4587
7	MA + 32 Hours	P	4662

Effective February 1, 2012

12-Month Lane	Educational Level	Pay Plan Code	Rate
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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

1	BA	E	4112
1	BA	L	4173
1	BA	P	4247
2	BA + 8 Hours	E	4112
2	BA + 8 Hours	L	4173
2	BA + 8 Hours	P	4247
3	BA + 16 Hours	E	4221
3	BA + 16 Hours	L	4281
3	BA + 16 Hours	P	4357
4	BA + 24 Hours	E	4317
4	BA + 24 Hours	L	4378
4	BA + 24 Hours	P	4455
5	MA	E	4414
5	MA	L	4480
5	MA	P	4557
6	MA + 16 Hours	E	4528
6	MA + 16 Hours	L	4593
6	MA + 16 Hours	P	4675
7	MA + 32 Hours	E	4609
7	MA + 32 Hours	L	4679
7	MA + 32 Hours	P	4755

Effective July 1, 2012

12-Month Lane	Educational Level	Pay Plan Code	Rate
1	BA	E	4112
1	BA	L	4173
1	BA	P	4247
2	BA + 8 Hours	E	4112
2	BA + 8 Hours	L	4173
2	BA + 8 Hours	P	4247
3	BA + 16 Hours	E	4221

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

3	BA + 16 Hours	E	4281
3	BA + 16 Hours	P	4357
4	BA + 24 Hours	E	4317
4	BA + 24 Hours	L	4378
4	BA + 24 Hours	P	4455
5	MA	E	4414
5	MA	L	4480
5	MA	P	4557
6	MA + 16 Hours	E	4528
6	MA + 16 Hours	L	4593
6	MA + 16 Hours	P	4675
7	MA + 32 Hours	E	4609
7	MA + 32 Hours	L	4679
7	MA + 32 Hours	P	4755

Effective May 20, 2013

12-Month Lane	Educational Level	Pay Plan Code	Hired on or after May 20, 2013	Hired before May 20, 2013
1	BA	E	3742	4112
1	BA	L	3797	4173
1	BA	P	3865	4247
2	BA + 8 Hours	E	3742	4112
2	BA + 8 Hours	L	3797	4173
2	BA + 8 Hours	P	3865	4247
3	BA + 16 Hours	E	3841	4221
3	BA + 16 Hours	L	3896	4281
3	BA + 16 Hours	P	3965	4357
4	BA + 24 Hours	E	3928	4317
4	BA + 24 Hours	L	3984	4378
4	BA + 24 Hours	P	4054	4455
5	MA	E	4017	4414
5	MA	L	4077	4480

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

5	MA	P	4147	4557
6	MA + 16 Hours	E	4120	4528
6	MA + 16 Hours	L	4180	4593
6	MA + 16 Hours	P	4254	4675
7	MA + 32 Hours	E	4194	4609
7	MA + 32 Hours	L	4258	4679
7	MA + 32 Hours	P	4327	4755

Effective July 1, 2013

12-Month Lane	Educational Level	Pay Plan Code	Hired on or after May 20, 2013	Hired before May 20, 2013
1	BA	E	3817	4194
1	BA	L	3873	4256
1	BA	P	3942	4332
2	BA + 8 Hours	E	3817	4194
2	BA + 8 Hours	L	3873	4256
2	BA + 8 Hours	P	3942	4332
3	BA + 16 Hours	E	3918	4305
3	BA + 16 Hours	L	3974	4367
3	BA + 16 Hours	P	4044	4444
4	BA + 24 Hours	E	4007	4403
4	BA + 24 Hours	L	4064	4466
4	BA + 24 Hours	P	4135	4544
5	MA	E	4097	4502
5	MA	L	4159	4570
5	MA	P	4230	4648
6	MA + 16 Hours	E	4202	4619
6	MA + 16 Hours	L	4264	4685
6	MA + 16 Hours	P	4339	4769
7	MA + 32 Hours	E	4278	4701
7	MA + 32 Hours	L	4343	4773
7	MA + 32 Hours	P	4414	4850

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Effective July 1, 2014

12-Month Lane	Educational Level	Pay Plan Code	Hired on or after May 20, 2013	Hired before May 20, 2013
1	BA	E	3893	4278
1	BA	L	3950	4341
1	BA	P	4021	4419
2	BA + 8 Hours	E	3893	4278
2	BA + 8 Hours	L	3950	4341
2	BA + 8 Hours	P	4021	4419
3	BA + 16 Hours	E	3996	4391
3	BA + 16 Hours	L	4053	4454
3	BA + 16 Hours	P	4125	4533
4	BA + 24 Hours	E	4087	4491
4	BA + 24 Hours	L	4145	4555
4	BA + 24 Hours	P	4218	4635
5	MA	E	4179	4592
5	MA	L	4242	4661
5	MA	P	4315	4741
6	MA + 16 Hours	E	4286	4711
6	MA + 16 Hours	L	4349	4779
6	MA + 16 Hours	P	4426	4864
7	MA + 32 Hours	E	4364	4795
7	MA + 32 Hours	L	4430	4868
7	MA + 32 Hours	P	4502	4947

~~Effective August 11, 2011~~

9-Month Lane	Educational Level	Pay Plan Code	Rate
†	BA	M	3024

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

1	BA	Ø	3024
2	BA + 8 Hours	M	3119
2	BA + 8 Hours	Ø	3119
3	BA + 16 Hours	M	3199
3	BA + 16 Hours	Ø	3199
4	BA + 24 Hours	M	3288
4	BA + 24 Hours	Ø	3288
5	MA	M	3389
5	MA	Ø	3389
6	MA + 16 Hours	M	3470
6	MA + 16 Hours	Ø	3470
7	MA + 32 Hours	M	3576
7	MA + 32 Hours	Ø	3576

Effective January 1, 2012

9-Month Lane	Educational Level	Pay Plan Code	Rate
1	BA	M	3062
1	BA	Ø	3062
2	BA + 8 Hours	M	3158
2	BA + 8 Hours	Ø	3158
3	BA + 16 Hours	M	3239
3	BA + 16 Hours	Ø	3239
4	BA + 24 Hours	M	3329
4	BA + 24 Hours	Ø	3329
5	MA	M	3431
5	MA	Ø	3431
6	MA + 16 Hours	M	3513
6	MA + 16 Hours	Ø	3513
7	MA + 32 Hours	M	3621
7	MA + 32 Hours	Ø	3621

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Effective February 1, 2012

9-Month Lane	Educational Level	Pay Plan Code	Rate
1	BA	M	3123
1	BA	Ø	3123
2	BA + 8 Hours	M	3221
2	BA + 8 Hours	Ø	3221
3	BA + 16 Hours	M	3304
3	BA + 16 Hours	Ø	3304
4	BA + 24 Hours	M	3396
4	BA + 24 Hours	Ø	3396
5	MA	M	3500
5	MA	Ø	3500
6	MA + 16 Hours	M	3583
6	MA + 16 Hours	Ø	3583
7	MA + 32 Hours	M	3693
7	MA + 32 Hours	Ø	3693

Effective July 1, 2012

9-Month Lane	Educational Level	Pay Plan Code	Rate
1	BA	M	3123
1	BA	Ø	3123
2	BA + 8 Hours	M	3221
2	BA + 8 Hours	Ø	3221
3	BA + 16 Hours	M	3304
3	BA + 16 Hours	Ø	3304
4	BA + 24 Hours	M	3396
4	BA + 24 Hours	Ø	3396
5	MA	M	3500

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

5	MA	Ø	3500
6	MA+16 Hours	M	3583
6	MA+16 Hours	Ø	3583
7	MA+32 Hours	M	3693
7	MA+32 Hours	Ø	3693

Effective May 20, 2013

9-Month Lane	Educational Level	Pay Plan Code	Hired on or after May 20, 2013	Hired before May 20, 2013
1	BA	M	2842	3123
1	BA	Ø	2842	3123
2	BA+8 Hours	M	2931	3221
2	BA+8 Hours	Ø	2931	3221
3	BA+16 Hours	M	3007	3304
3	BA+16 Hours	Ø	3007	3304
4	BA+24 Hours	M	3090	3396
4	BA+24 Hours	Ø	3090	3396
5	MA	M	3185	3500
5	MA	Ø	3185	3500
6	MA+16 Hours	M	3261	3583
6	MA+16 Hours	Ø	3261	3583
7	MA+32 Hours	M	3361	3693
7	MA+32 Hours	Ø	3361	3693

Effective July 1, 2013

9-Month Lane	Educational Level	Pay Plan Code	Hired on or after May 20, 2013	Hired before May 20, 2013
1	BA	M	2899	3185
1	BA	Ø	2899	3185
2	BA+8 Hours	M	2990	3285
2	BA+8 Hours	Ø	2990	3285
3	BA+16 Hours	M	3067	3370

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

3	BA + 16 Hours	Ø	3067	3370
4	BA + 24 Hours	M	3152	3464
4	BA + 24 Hours	Ø	3152	3464
5	MA	M	3249	3570
5	MA	Ø	3249	3570
6	MA + 16 Hours	M	3326	3655
6	MA + 16 Hours	Ø	3326	3655
7	MA + 32 Hours	M	3428	3767
7	MA + 32 Hours	Ø	3428	3767

Effective July 1, 2014

9-Month Lane	Educational Level	Pay Plan Code	Hired on or after May 20, 2013	Hired before May 20, 2013
1	BA	M	2957	3249
1	BA	O	2957	3249
2	BA + 8 Hours	M	3050	3351
2	BA + 8 Hours	O	3050	3351
3	BA + 16 Hours	M	3128	3437
3	BA + 16 Hours	O	3128	3437
4	BA + 24 Hours	M	3215	3533
4	BA + 24 Hours	O	3215	3533
5	MA	M	3314	3641
5	MA	O	3314	3641
6	MA + 16 Hours	M	3393	3728
6	MA + 16 Hours	O	3393	3728
7	MA + 32 Hours	M	3497	3842
7	MA + 32 Hours	O	3497	3842

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE Z RC-063 (Physicians, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Physician	32200	RC-063	MD
Physician Specialist, Option A	32221	RC-063	MD-A
Physician Specialist, Option B	32222	RC-063	MD-B
Physician Specialist, Option C	32223	RC-063	MD-C
Physician Specialist, Option D	32224	RC-063	MD-D
Physician Specialist, Option E	32225	RC-063	MD-E

NOTES: Shift Differential Pay – Employees shall be paid a shift differential of \$0.80 per hour in addition to their base salary rate for all hours worked if their normal work schedule for that day provides that they are scheduled to work and they work ½ or more of the work hours before 7 a.m. or after 3 p.m. The payment shall be for all paid time. Incumbents who currently receive a percentage shift differential providing more than the cents per hour indicated in this Note based on the base rate of pay prior to the effective date shall have that percentage converted to the cents per hour equivalent rounded to the nearest cent and shall continue to receive the higher cents per hour rate. This provision shall not apply to employees who, because of "flex-time" scheduling made at their request, are scheduled and work hours that would otherwise qualify them for premium pay under this provision.

Longevity Pay – Effective January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 7 in the same or higher pay grade on or before January 1, 2002, the Step 8 rate shall be increased by \$50 per month. For employees not eligible for longevity pay on or before January 1, 2002, the Step 8 rate shall be increased by \$25 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade, the Step 8 rate shall be increased by \$50 per month. Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, the Step 6 rate shall be increased by \$25 per month to \$75 a month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 6 in the same or higher pay grade on or before July 1, 2013. For those employees who attain 15 years of continuous service and have three or more years of creditable service on Step 6 in the same or higher pay grade on or before July 1, 2013, the Step 6 rate shall be increased by \$25 per month to \$100 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 6 while they remain in the same or lower pay grade.

Effective July 1, 2012
Bargaining Unit: RC-063

Pay Grade	Pay Plan Code	STEPS					
		1	2	3	4	5	6
MD	B	9983	10557	11135	11710	12292	12862
MD	Q	10435	11033	11637	12239	12844	13442
MD	S	10516	11116	11723	12324	12927	13528
MD-A	B	10557	11210	11864	12517	13168	13819
MD-A	Q	11033	11718	12397	13085	13765	14446
MD-A	S	11116	11798	12482	13167	13850	14529
MD-B	B	11515	12204	12900	13588	14284	14976

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MD-B	Q	12039	12756	13484	14205	14927	15651
MD-B	S	12120	12842	13568	14287	15010	15735
MD-C	B	12862	13627	14401	15165	15933	16700
MD-C	Q	13442	14245	15051	15849	16653	17453
MD-C	S	13528	14328	15132	15934	16734	17539
MD-D	B	14401	15165	15933	16700	17466	18235
MD-D	Q	15051	15849	16653	17453	18260	19060
MD-D	S	15132	15934	16734	17539	18340	19141
MD-E	B	15264	16076	16891	17704	18521	19330
MD-E	Q	15953	16802	17655	18503	19355	20203
MD-E	S	16040	16883	17735	18585	19439	20288

Effective May 20, 2013
Bargaining Unit: RC-063

Pay Grade	Pay Plan Code	S T E P S								
		1e	1b	1a	1	2	3	4	5	6
MD	B	9085	9384	9684	9983	10557	11135	11710	12292	12862
MD	Q	9496	9809	10122	10435	11033	11637	12239	12844	13442
MD	S	9570	9885	10201	10516	11116	11723	12324	12927	13528
MD-A	B	9607	9924	10240	10557	11210	11864	12517	13168	13819
MD-A	Q	10040	10371	10702	11033	11718	12397	13085	13765	14446
MD-A	S	10116	10449	10783	11116	11798	12482	13167	13850	14529
MD-B	B	10479	10824	11170	11515	12204	12900	13588	14284	14976
MD-B	Q	10955	11317	11678	12039	12756	13484	14205	14927	15651
MD-B	S	11029	11393	11756	12120	12842	13568	14287	15010	15735
MD-C	B	11704	12090	12476	12862	13627	14401	15165	15933	16700

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NOTICE OF ADOPTED AMENDMENTS

MD-C	Q	12232	12635	13039	13442	14245	15051	15849	16653	17453
MD-C	S	12310	12716	13122	13528	14328	15132	15934	16734	17539
MD-D	B	13105	13537	13969	14401	15165	15933	16700	17466	18235
MD-D	Q	13696	14148	14599	15051	15849	16653	17453	18260	19060
MD-D	S	13770	14224	14678	15132	15934	16734	17539	18340	19141
MD-E	B	13890	14348	14806	15264	16076	16891	17704	18521	19330
MD-E	Q	14517	14996	15474	15953	16802	17655	18503	19355	20203
MD-E	S	14596	15078	15559	16040	16883	17735	18585	19439	20288

Effective July 1, 2013
Bargaining Unit: RC-063

Pay Grade	Pay Plan Code	STEPS								
		1e	1b	1a	1	2	3	4	5	6
MD	B	9267	9572	9878	10183	10768	11358	11944	12538	13119
MD	Q	9686	10005	10324	10644	11254	11870	12484	13101	13711
MD	S	9761	10083	10405	10726	11338	11957	12570	13186	13799
MD-A	B	9799	10122	10445	10768	11434	12101	12767	13431	14095
MD-A	Q	10241	10578	10916	11254	11952	12645	13347	14040	14735
MD-A	S	10318	10658	10999	11338	12034	12732	13430	14127	14820
MD-B	B	10689	11040	11393	11745	12448	13158	13860	14570	15276
MD-B	Q	11174	11543	11912	12280	13011	13754	14489	15226	15964
MD-B	S	11250	11621	11991	12362	13099	13839	14573	15310	16050
MD-C	B	11938	12332	12726	13119	13900	14689	15468	16252	17034
MD-C	Q	12477	12888	13300	13711	14530	15352	16166	16986	17802
MD-C	S	12556	12970	13384	13799	14615	15435	16253	17069	17890
MD-D	B	13367	13808	14248	14689	15468	16252	17034	17815	18600

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MD-D	Q	13970	14431	14891	15352	16166	16986	17802	18625	19441
MD-D	S	14045	14508	14972	15435	16253	17069	17890	18707	19524
MD-E	B	14168	14635	15102	15569	16398	17229	18058	18891	19717
MD-E	Q	14807	15296	15783	16272	17138	18008	18873	19742	20607
MD-E	S	14888	15380	15870	16361	17221	18090	18957	19828	20694

Effective July 1, 2014
Bargaining Unit: RC-063

Pay Grade	Pay Plan Code	S T E P S								
		1c	1b	1a	1	2	3	4	5	6
MD	B	9452	9763	10076	10387	10983	11585	12183	12789	13381
MD	Q	9880	10205	10530	10857	11479	12107	12734	13363	13985
MD	S	9956	10285	10613	10941	11565	12196	12821	13450	14075
MD-A	B	9995	10324	10654	10983	11663	12343	13022	13700	14377
MD-A	Q	10446	10790	11134	11479	12191	12898	13614	14321	15030
MD-A	S	10524	10871	11219	11565	12275	12987	13699	14410	15116
MD-B	B	10903	11261	11621	11980	12697	13421	14137	14861	15582
MD-B	Q	11397	11774	12150	12526	13271	14029	14779	15531	16283
MD-B	S	11475	11853	12231	12609	13361	14116	14864	15616	16371
MD-C	B	12177	12579	12981	13381	14178	14983	15777	16577	17375
MD-C	Q	12727	13146	13566	13985	14821	15659	16489	17326	18158
MD-C	S	12807	13229	13652	14075	14907	15744	16578	17410	18248
MD-D	B	13634	14084	14533	14983	15777	16577	17375	18171	18972
MD-D	Q	14249	14720	15189	15659	16489	17326	18158	18998	19830
MD-D	S	14326	14798	15271	15744	16578	17410	18248	19081	19914

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MD-E	B	14451	14928	15404	15880	16726	17574	18419	19269	20111
MD-E	Q	15103	15602	16099	16597	17481	18368	19250	20137	21019
MD-E	S	15186	15688	16187	16688	17565	18452	19336	20225	21108

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE AC RC-036 (Public Service Administrators Option 8L Department of Healthcare and Family Services, INA)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Plan Code</u>
Public Service Administrator, Option 8L (Department of Healthcare and Family Services' Office of Inspector General's Bureau of Administrative Legislation)	37015	RC-036	B

NOTE: Longevity Pay – Effective September 23, 2013, the Step 8 rate shall be increased by \$75 a month for employees who attain 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. Employees who attain 15 years of continuous services 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 shall increase by \$100 a month.

Effective July 1, 2012**STEPS**

<u>1e</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>
5775	5948	6126	6309	6644	6994	7327	7667	8012	8515	8855

Effective July 1, 2013**STEPS**

<u>1e</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>
5891	6067	6249	6435	6777	7134	7474	7820	8172	8685	9032

Effective July 1, 2014**STEPS**

<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>
6008	6188	6373	6564	6912	7277	7623	7977	8336	8859	9213

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE AD RC-184 (Blasting Experts, Blasting Specialists and Blasting Supervisors Department of Natural Resources, SEIU Local 73)**

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

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
Bargaining Unit: RC-184

Pay Grade	Pay Plan Code	S T E P S										
		1e	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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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

(Source: Amended at 38 Ill. Reg. 14818, effective July 1, 2014)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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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>Proposed Action:</u>
140.11	Amendment
140.16	Amendment
140.71	Amendment
140.402	Amendment
140.459	Amendment
140.461	Amendment
140.462	Amendment
140.464	Amendment
140.930	Amendment
140.Table J	New Section
140.Table M	Repeal
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11]
- 5) Effective Date of Rule: July 2, 2014
- 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 rule, 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 21, 2014; 38 Ill. Reg. 4559
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences Between Proposal and Final Version: In subsection 140.459(b)(1) of Section of 140.459 added new subsection "140.459(b)(1)(D)": "That is a Critical Access Hospital, as defined in Section 148.25(g), the rate shall be based on costs set as of June

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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30, 2012, pursuant to Public Act 96-1382, and exempt from the 3.5% rate reduction identified in Public Act 97-0689."

In subsection (a) of Section 140.459, after "of" strike the colon and add "the following. The rate shall not exceed the upper limits set in federal regulations at 42 CFR 447.321 (2012) and reimbursement is based upon the applicable modifier billed by the provider."

In subsection (b)(2) of Section 140.459, add subsection label "D)" and change "Section" to "89 Ill. Adm. Code".

In subsection (a)(2) of Section 140.461 changed to read as follows:

"2) For all other therapy services (paid per quarter hour), rates shall be as published on the Department's website in the Therapy Fee Schedule located at <http://www2.illinois.gov/hfs/MedicalProvider/MedicaidReimbursement/Pages/TherapyFeeSchedule.aspx>."

- 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 rule currently in effect? No
- 14) Are there any other rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
140.12	Amendment	37 Ill. Reg. 19971; December 20, 2013
140.440	Amendment	37 Ill. Reg. 19971; December 20, 2013

- 15) Summary and Purpose of Rulemaking: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform. These rules have also been modified based on negotiations for SB 741 of the 98th General Assembly which become law June 16, 2014 (Public Act 98-651).
- 16) Information and questions regarding these adopted rules shall be directed to:

Jeanette Badrov
 General Counsel
 Illinois Department of Healthcare and Family Services

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763-0002

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

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, 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

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- 140.18 Effect of Termination, Suspension, Exclusion or Revocation on Persons 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 Electronic Data Interchange Service
- 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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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140.84	Long Term Care Provider Fund
140.94	Medicaid Developmentally Disabled Provider Participation Fee Trust 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)
140.98	Covered Hospital Services (Recodified)
140.99	Hospital Services Not Covered (Recodified)
140.100	Limitation On Hospital Services (Recodified)
140.101	Transplants (Recodified)
140.102	Heart Transplants (Recodified)
140.103	Liver Transplants (Recodified)
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)
140.360	Payment Methodology (Recodified)
140.361	Non-Participating Hospitals (Recodified)
140.362	Pre July 1, 1989 Services (Recodified)
140.363	Post June 30, 1989 Services (Recodified)
140.364	Prepayment Review (Recodified)
140.365	Base Year Costs (Recodified)
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)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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- 140.375 Exemptions (Recodified)
- 140.376 Utilization, Case-Mix and Discretionary Funds (Repealed)
- 140.390 Subacute Alcoholism and Substance Abuse Services (Recodified)
- 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

- Section
- 140.400 Payment to Practitioners
- 140.402 Copayments for Noninstitutional Medical Services
- 140.403 Telehealth Services
- 140.405 Non-Institutional Rate Reductions
- 140.410 Physicians' Services
- 140.411 Covered Services By Physicians
- 140.412 Services Not Covered By Physicians
- 140.413 Limitation on Physician Services
- 140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items – Prescribers
- 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

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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 and 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

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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 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

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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 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.

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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; 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.

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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 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;

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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 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.

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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 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 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

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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; peremptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; peremptory 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; peremptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days; emergency expired April 10, 2009; peremptory 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

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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; amended at 37 Ill. Reg. 12855, effective July 24, 2013; emergency amendment at 37 Ill. Reg. 14196, effective August 20, 2013, for a maximum of 150 days; amended at 37 Ill. Reg. 17584, effective October 23, 2013; amended at 37 Ill. Reg. 18275, effective November 4, 2013; amended at 37 Ill. Reg. 20339, effective December 9, 2013; amended at 38 Ill. Reg. 859, effective December 23, 2013; emergency amendment at 38 Ill. Reg. 1174, effective January 1, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. 4330, effective January 29, 2014; amended at 38 Ill. Reg. 7156, effective March 13, 2014; amended at 38 Ill. Reg. 12141, effective May 30, 2014; amended at 38 Ill. Reg. 15081, effective July 2, 2014.

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.;

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- 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.;
 - 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.
 - c) Except for children's hospitals described at 89 Ill. Adm. Code ~~148.25(d)(3)(B)+49.50(e)(3)~~, hospitals providing inpatient care that are certified under a single ~~Centers for Medicare and Medicaid Services certification~~ Medicare number shall be enrolled as ~~a single~~ ~~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(1) 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,

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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 ~~disenrollment~~~~dis-enrollment~~ of the provider from the Program. Such ~~disenrollment~~~~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 ~~disenrolled~~~~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.
- g) Anything in this Subpart B to the contrary notwithstanding, enrollment of a vendor is subject to a provisional period and shall be conditional for one year unless limited by the Department. During the period of conditional enrollment, 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 vendor under this subsection (g), the following individuals shall be barred from participation in the Medical Assistance Program:
- 1) ~~Individuals~~~~individuals~~ with management responsibility;
 - 2) ~~All~~~~all~~ owners or partners in a partnership;

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- 3) ~~AllaH~~ 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) ~~AnaH~~ owner of a sole proprietorship.
- h) Unless otherwise specified, the termination of eligibility or vendor disenrollment, as described in subsection (g) of this Section, and resulting barrments are not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

(Source: Amended at 38 Ill. Reg. 15081, effective July 2, 2014)

Section 140.16 Termination, Suspension or Exclusion of a Vendor's Eligibility to Participate in the Medical Assistance Program

- a) ~~TheEffective July 1, 2012, the~~ Department may terminate or suspend a vendor's eligibility to participate in the Medical Assistance Program, 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)~~;
 - 2) The vendor, person or entity is not properly licensed, certified, authorized or otherwise qualified, or the vendor person's or entity'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.

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- 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 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:

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- A) in excess of needs;
 - B) harmful (for the purpose of this subsection (a)(7)(B), "harmful" goods or services cause actual harm as defined in Section 140.13 or place an individual at risk of harm, or of adverse side effects, that outweigh the medical benefits sought); 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) The vendor engaged in practices prohibited by 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 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 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 or State law or regulation; or

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- 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 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 or State law or regulation;
- B) For purposes of this subsection (a)(10), "applicable federal or State law or regulation" includes, but is not limited to, licensing or certification standards contained in State or 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 or State laws or regulations related to the Medical Assistance Program;
- C) For purposes of this subsection (a)(10), conviction or a plea of guilty to activities violative of applicable federal or State law or regulation shall be conclusive proof that those activities were engaged in;
- 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 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 not related to the Medical Assistance Program, if the offense constitutes grounds for disciplinary action under the licensing Act applicable to that individual or vendor;
- 12) 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

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vendor has been convicted in this or any other state, or in any Federal Court, of:

- A) murder;
 - 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) 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 to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin 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 [Illinois 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.

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- c) ~~The 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 38 Ill. Reg. 15081, effective July 2, 2014)

Section 140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments

- a) C-13 Invoice Voucher Advance Payments
- 1) The C-13 invoice voucher, when used as an advanced payment, is an exception to the regular reimbursement process. It may be issued only under extraordinary circumstances to qualified providers of medical assistance services. C-13 advance payments will be made only to a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:
 - A) are enrolled with the Department ~~of Public Aid~~;
 - B) have experienced an emergency which necessitates C-13 advance payments. Emergency in this instance is defined as a circumstance under which withholding of the advance payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:
 - i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired; or
 - ii) cash flow problems encountered by a provider or group of providers which are unrelated to agency technical system problems. These situations include problems which are exclusively those of the providers or problems related to State cash flow which result in delayed payments and

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extensive financial problems to a provider, adversely impacting on the ability to promptly serve the clients;

- C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:
- i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;
 - ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;
 - iii) for hospitals, the hospital must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;
 - iv) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;
 - v) for sole source pharmacies in a community which are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;
 - vi) for government-owned facilities, this subsection (a)(1)(C) may be waived if the cash flow ~~criteria~~criteria under subsection (a)(1)(B)(ii) is met; and
 - vii) for providers who have filed for Chapter 11 bankruptcy, this subsection (a)(1)(C) may be waived if the cash flow ~~criteria~~criteria under subsection (a)(1)(B)(ii) are met;
- D) sign an agreement with the Department which specifies the terms of advance payment and subsequent repayment. The agreement will contain the following provisions:

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- i) specific ~~reasons~~reason(s) for advanced payments;
 - ii) specific amount agreed to be advanced;
 - iii) specific date to begin recoupment; and
 - iv) method of recoupment (percentage of payable amount of each Medicaid Management Information System (MMIS) voucher, specific amount per month, a warrant intercept, or a combination of the three recovery methods).
- 2) Determination of amount of payment to be issued shall be based on anticipated future payments as determined by the Department.
- 3) Approval Process
- A) In order to obtain C-13 advance payments, providers must submit their request in writing (~~telefacsimile and email~~telefax requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:
 - i) an explanation of the circumstances creating the need for the advance payments;
 - ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and
 - iii) specification of the amount of the advance required.
 - B) An agreement will 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 release of the warrant.
 - C) C-13 advance payments shall be authorized for the provider following approval by the ~~Medicaid~~Administrator of the Division of Medical Programs or designee. Once all requirements of this

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subsection (a)(3) are met, the Administrator will authorize payment within seven days.

- 4) Recoupment
 - A) Health care entities other than individual practitioners shall be required to sign an agreement stating that, should the entity be sold, the new owners will be made aware of the liability and will assume responsibility for repaying the debt to the Department according to the original agreement.
 - B) All providers shall sign an agreement specifying the terms of recoupment. An agreed percentage of the total payment to the provider for services rendered shall be deducted from future payments until the debt is repaid. For providers who are properly certified, licensed or otherwise qualified under appropriate State and federal requirements, the recoupment period shall not exceed six months from the month in which payment is authorized. For those providers enrolled but not in good standing (e.g., decertification termination hearing or other adverse action is pending), recoupment will be made from the next available payments owed the provider.
 - C) In the event that the provider fails to comply with the recoupment terms of the agreement, the remaining balance of any advance payment shall be immediately recouped from claims being processed by the Department. If such claims are insufficient for complete recovery, the remaining balance will become immediately due and payable by check to the Illinois Department of Public Aid. Failure by the provider to remit such check will result in the Department pursuing other collection methods.
- 5) Prior Agreements
The terms of any agreement signed between the provider and the Department prior to the adoption of this [Section or prior to any amendment to this Section](#)~~rule~~ will remain in effect, notwithstanding the provisions of this Section.

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b) Expedited Claims Payments

- 1) Expedited claims payments are issued through the regular MMIS payment process and represent an acceleration of the regular payment schedule. They may be issued only under extraordinary circumstances to qualified providers of medical assistance services. Reimbursement through the expedited process will be made only to a hospital qualified and participating under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:
 - A) are enrolled with the Department ~~of Public Aid~~;
 - B) have experienced an emergency which necessitates expedited payments. Emergency in this instance is defined as a circumstance under which withholding of the expedited payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:
 - i) agency system errors (either automated system or clerical) ~~that~~which have precluded payments, or ~~that~~which have caused erroneous payments such that the provider's ability to provide further services to the clients is severely impaired;
 - ii) cash flow problems encountered by a provider or group of providers which are unrelated to Department technical system problems. These situations include problems which are exclusively those of the providers (i.e., provider billing system problems) or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider adversely impacting on the ability to serve the clients;
 - C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

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- i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;
- ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;
- iii) for hospitals, the hospitals must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;
- ~~iv) for hospitals that qualify as disproportionate share hospitals as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122 and receive Rehabilitation Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(b)) or Direct Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(c)(1)), a request must be made in writing that demonstrates proof of cash flow problems;~~
- ~~iv)~~ for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;
- ~~v)~~ for sole source pharmacies in a community that are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;
- ~~vii)~~ for government-owned facilities, this subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (a)(1)(B)(ii) are met; and
- ~~viii)~~ for providers who have filed for Chapter 11 bankruptcy, subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (b)(1)(B)(ii) are met.

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- 2) Reimbursement will be based upon the amount of claims determined payable and be made for a period specified by the Department.
- 3) Approval Process
 - A) In order to qualify for expedited payments, providers must submit their request in writing (~~telefacsimile and email~~~~telefax~~ requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:
 - i) an explanation of the need for the expedited payments; and
 - ii) supportive documentation to substantiate the emergency nature of the request.
 - B) Expedited payments shall be authorized for the provider following approval by the ~~Medicaid~~ Administrator of the Division of Medical Programs or designee.
 - C) The Department will periodically review the need for any continued expedited payments.
- 4) Prior Agreements
The terms of any agreement signed between the provider and the Department prior to the adoption of this Section or prior to any amendment to this Section~~rule~~ will remain in effect, notwithstanding the provisions of this Section.

(Source: Amended at 38 Ill. Reg. 15081, effective July 2, 2014)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.402 Copayments for Non-institutional Medical Services

The following implements cost sharing in compliance with 42 USC 1396o (section 1916 of the Social Security Act):

- a) Each~~Effective July 1, 2012, each~~ recipient, with the exception of those classes of

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recipients identified in subsection (d) of this Section, shall 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 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 non-institutional medical services:

- 1) Office visits to enrolled practitioners for services reimbursed under the [Illinois](#) Public Aid Code.
 - 2) Each brand name legend drug billed to the Department.
 - 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) 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):
 - 1) Pregnant women, including a postpartum period of 60 days.
 - 2) Children under 19 years of age.

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- 3) All non-institutionalized 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).
 - 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.
 - 5) Services for which Medicare is the primary payer.

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- 6) 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).
- 7) Any pharmacy compounded drugs.
- 8) Any prescription (legend drug) dispensed or administered by a hospital, clinic or physician.
- 9) 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 financial participation 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) 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 38 Ill. Reg. 15081, effective July 2, 2014)

Section 140.459 Payment for Therapy Services

- a) Therapy services shall be paid at an all-inclusive per half hour rate ~~that~~ which shall be the lower of the following. The rate shall not exceed the upper limits set in federal regulations at 42 CFR 447.321 (2012) and reimbursement is based upon the applicable modifier billed by the provider.
 - 1a) The ~~provider's~~ providers usual and customary charge for services ~~of~~
 - 2b) The maximum reimbursement rate established by the Department.
- b) Maximum Reimbursement Rates. The maximum reimbursement rate:
 - 1) For outpatient physical rehabilitation services provided by a hospital (paid per visit and limited to one visit per day):

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- A) That is a children's hospital, as defined in 148.25(d)(3)(A), enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00.
 - B) Enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00.
 - C) Not enrolled with the Department to provide outpatient physical rehabilitation shall be \$115.00.
 - D) That is a Critical Access Hospital, as defined in 89 Ill. Adm. Code 148.25(g), the rate shall be based on costs set as of June 30, 2012, pursuant to Public Act 96-1382, and exempt from the 3.5% rate reduction identified in Public Act 97-689.
- 2) For all other therapy services (paid per quarter hour), rates shall be as published on the Department's website in the Therapy Fee Schedule located at <http://www2.illinois.gov/hfs/MedicalProvider/Medicaid/Reimbursement/Pages/TherapyFeeSchedule.aspx>.

(Source: Amended at 38 Ill. Reg. 15081, effective July 2, 2014)

Section 140.461 Clinic Participation, Data and Certification Requirements

- a) Hospital-based organized clinics must:
 - 1) Have an administrative structure, staff program, physical setting, and equipment to provide comprehensive medical care.;
 - 2) Agree to assume complete responsibility for diagnosis and treatment of the patients accepted by the clinic, or provide, at no additional cost to the Department, for the acquisition of these services through contractual arrangements with external medical providers.;
 - 3) Meet one of the following requirements:
 - A) Be adjacent to or on the premises of athe hospital and be

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- i) licensed under the Hospital Licensing Act or the University of Illinois Hospital Act; or
 - ii) that meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.
- B) ~~Have~~ provider-based status under Medicare pursuant to 42 CFR 413.65 ~~or~~
- C) ~~Be~~ clinically integrated as evidenced by all of the following:
- i) ~~Professional~~ professional staff of the clinic have clinical privileges at the main hospital; the main hospital maintains the same monitoring and oversight of the clinic as it does for any other department of the hospital; medical staff committees or other professional committees at the main hospital are responsible for medical activities in the clinic, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the clinic and the main hospital; medical records for patients treated in the clinic are integrated into a unified retrieval system of the main hospital, or cross reference that retrieval system; and inpatient and outpatient services of the clinic and the main hospital are integrated, and patients treated at the clinic who require further care have full access to all services of the main hospital and are referred when appropriate to the corresponding inpatient or outpatient department or service of the main hospital ~~and~~
 - ii) ~~Fully~~ fully integrated within the financial system of the main hospital, as evidenced by shared income and expenses between the main hospital and the clinic ~~and~~
 - iii) ~~Held~~ held out to the public and other payers as part of the main hospital ~~and~~

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- iv) ~~Operated~~operated under the ownership and control of the main hospital, as evidenced by the following: the business enterprise that constitutes the clinic is 100 percent owned by the main hospital; the main hospital and the clinic have the same governing body; the clinic is operated under the same organizational documents (e.g., bylaws and operating decisions) as the main hospital; and the main hospital has final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the clinic. ~~;~~ and
 - v) ~~Located~~located within a 35 mile radius of the main hospital campus as defined in 42 CFR 413.65.
- 4) Meet the applicable requirements of 89 Ill. Adm. Code 148.40(d).
- b) Encounter Rate Clinics
- 1) Encounter rate clinics must:
 - A) ~~have participated~~participate in the Medical Assistance Program as an encounter rate clinic as of July 1, 1998; ~~;~~ or
 - B) be a clinic operated by an Illinois county with a population of over three million.
 - 2) Individual practitioners associated with ~~these clinics~~such centers may apply for participation in the Medical Assistance Program in their individual capacities. In order to participate in the Maternal and Child Health Program, as described in Subpart G, encounter rate clinics shall be required to meet the additional participation requirements described in Section 140.924(a)(2).
- c) Rural health clinics must be certified by the Centers for Medicare and Medicaid Services~~Health Care Financing Administration~~ as meeting the requirements for Medicare participation.

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- d) Federally Qualified Health Centers (FQHC):
- 1) Must ~~meet one of the following criteria~~ ~~be Health Centers which:~~
 - A) ~~Receive~~ ~~receive~~ a grant under Section 329, 330 or 340 of the Public Health Service Act ~~(42 USC 329, 330 or 340).~~ ~~;~~ ~~or~~
 - B) ~~Based~~ ~~based~~ on the recommendation of the Health Resources and Services Administration within the U.S. Department of Health and Human Services ~~Public Health Service~~, ~~be~~ ~~are~~ determined to meet the requirements for receiving ~~such~~ a grant.
 - 2) ~~Section 4602 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which amended~~ Section 1902(a)(55) of the Social Security Act (42 USC ~~Section~~ 1396a(a)(55)), requires states to receive and initially process Medicaid applications from low-income pregnant women and children under 19 years of age at locations other than the local Department of Human Services (DHS) office. ~~These sites are~~ ~~Such a site is~~ referred to as ~~outstations~~ ~~an outstation~~.
 - A) Outstations will be located at those FQHCs ~~that~~ ~~which~~ the Department determines serve heavy Medicaid populated areas. For areas in which the Department determines that maintaining outstation workers is not economical, the DHS Family Community Resource Center (FCRC) ~~local office~~ will continue to be the application location.
 - B) The FQHCs, which will provide outstation eligibility staff to accept and assist in the initial processing of the Medicaid application for pregnant women and children, will forward the completed application to the appropriate DHS FCRC ~~local office~~. Initial processing means accepting and completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete and conducting any necessary interviews. Neither the FQHCs nor the outstation workers will evaluate the information contained on the application, nor make any determination of eligibility or

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ineligibility. The DHS ~~FCRC local office~~ is responsible for these functions.

- C) Costs allowable under the federal outstation mandate for completing the Medicaid application will be itemized in Section B of Schedule I of the FQHC Medicaid cost report and will be provided annually in the FQHC cost reporting process. These allowable costs will be collected, computed and calculated, and will result in the establishment of an outstation administrative rate and a Medicaid rate. The allowable costs are:
- i) Salary of outstation worker.;
 - ii) Fringe benefits.;
 - iii) Training.;
 - iv) Travel. ~~and~~
 - v) Supplies.
- D) FQHC outstation workers must receive certification through Maternal and Child Health (MCH) process training by the Department before they begin to perform eligibility processing functions. Failure to become certified results in any MCH application completed by an ineligible worker being non-allowed on the cost report.
- E) FQHCs must have adequate staff trained with proper backup to accommodate unforeseen problems. FQHCs must be able to meet the demand of this initiative, either using staff at one location or rotating staff as dictated by workload or staffing availability. The FQHC must have staff available at each outstation location during regular office operating hours.
- F) Outstation intake staff may perform other FQHC intake processing functions, but the time spent on outstation activities must be documented and must be identifiable for cost reporting and

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auditing purposes.

- G) The FQHC must display a notice in a prominent place at the outstation location advising potential applicants of the times that outstation intake workers will be available. The notice must include a telephone number that applicants may call for assistance.
 - H) The FQHC must comply with federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.
- e) Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities.

f) ~~Maternal and Child Health Clinics~~

1) ~~Types of Clinics~~

~~The following clinics shall qualify as Maternal and Child Health Clinics:~~

- A) ~~Certified Hospital Ambulatory Primary Care Centers (CHAPCC) that are hospital-based organized outpatient clinics, as described in subsection (a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide ambulatory primary care to Medicaid children from birth through 20 years of age, and pregnant women in a non-emergency room setting. At least 50 percent of all staff physicians providing care in a CHAPCC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHAPCC must be for primary care.~~
- B) ~~Certified Hospital Organized Satellite Clinics (CHOSC) that are clinics meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that are owned, operated, and/or managed by a hospital but do not qualify as hospital-based organized clinics, as described in subsection (a),~~

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~~because they are not located adjacent to or on the premises of the hospital or are not licensed under the Hospital Licensing Act or the University of Illinois Hospital Act. Through staff and supporting resources, these clinics provide ambulatory primary care in a non-emergency setting to Medicaid children from birth through 20 years of age, and to pregnant women. At least 50 percent of all staff physicians providing care in a CHOSC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHOSC must be for primary care. Primary care consists of basic health services provided by a physician or other qualified medical professional to maintain the day-to-day health status of a patient, without requiring the level of medical technology and specialized expertise necessary for the provision of secondary and tertiary care. CHOSCs shall meet the requirements in subsections (a)(1) and (a)(2).~~

- ~~C) Certified Obstetrical Ambulatory Care Centers (COBACC) that are hospital-based organized clinic entities, as described in subsection (a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide primary care and specialty services to Medicaid-eligible pregnant women, especially those determined to be non-compliant or at high risk, in an outpatient setting.~~
- ~~D) Certified Pediatric Ambulatory Care Centers (CPACC) that are hospital-based organized clinic entities, as described in subsection (a), owned and operated by a hospital as described in 89 Ill. Adm. Code 149.50(e)(3), and meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide pediatric primary care and specialty services as described in Section 140.462(e)(3)(C) to Medicaid-enrolled children with specialty needs, from birth through 20 years of age in an outpatient setting. Hospitals with CPACCs must also provide primary care for at least 1,500 children, either through its CPACC or through a CHAPCC, CHOSC or encounter rate clinic operated by the same~~

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~~hospital. Hospitals unable to meet this volume requirement must agree to serve as a specialty referral site for another hospital operating a CPACC through a written agreement submitted to the Department.~~

- 2) ~~General Participation Requirements~~
In addition to the Maternal and Child Health participation requirements described in Section 140.924(a)(1), the Maternal and Child Health clinics identified in subsection (f)(1) must:
- A) ~~Be operated by a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120, be staffed by board certified/eligible physicians who have hospital admitting and/or delivery privileges, be operated by a hospital in an organized corporate network of hospitals having a total of more than 1,000 staffed beds, and agree to provide care for a minimum of 100 pregnant women or children; or be a primary care teaching site of an organized academic department of:~~
- i) ~~In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information.~~
- ii) ~~In the case of clinics described in subsection (f)(1)(C), an obstetrical residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.~~
- iii) ~~In the case of clinics described in subsection (f)(1)(D), a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.~~
- B) ~~Under the direction of a board certified/eligible physician who has~~

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~~hospital admitting and/or delivery privileges and provides direct supervision to residents practicing in the certified ambulatory site, provide:~~

- ~~i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), primary care.~~
 - ~~ii) In the case of clinics described in subsection (f)(1)(C), obstetric and specialty services.~~
 - ~~iii) In the case of clinics described in subsection (f)(1)(D), primary care and specialty services.~~
- ~~C) Maintain a formal, ongoing quality assurance program that meets the minimum standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO);~~
- ~~D) Provide historical evidence of fiscal solvency and financial projections for the future, in a manner specified by the Department; and~~
- ~~E) Utilize a formal client tracking and care management system that affords timely maintenance of, access to, and continuity of medical records without compromising client confidentiality.~~
- 3) ~~Special Participation Requirements~~
~~In addition to the Maternal and Child Health provider participation requirements described in Section 140.924(a)(1), and the general participation requirements described in subsection (f)(2), special participation requirements shall apply as follows:~~
- ~~A) Clinics described in subsections (f)(1)(A) and (f)(1)(B) must:~~
 - ~~i) Serve a total population that includes at least 20 percent Medicaid and medically indigent clients;~~
 - ~~ii) Perform a risk assessment on pregnant women assigned to them in order to determine if the woman is at high risk; and~~

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- iii) ~~Provide or arrange for specialty services when needed by pregnant women or children.~~
- B) ~~Clinics described in subsection (f)(1)(C) must:~~
 - i) ~~Be a distinct department of a hospital that also operates as a Level II, Level II with Extended Neonatal Capabilities or Level III perinatal center;~~
 - ii) ~~Provide services to pregnant women demonstrating the need for extensive health care services due to complicated medical conditions placing them potentially at high risk of abnormal delivery, including substance abuse or addiction problems. Hospital clinics will not qualify to participate unless they provide both primary and specialty services to women who currently are Medicaid clients, or Medicaid-eligible women who receive services at the COBACC; in this capacity, COBACCs, as perinatal centers, shall serve pregnant women determined to be at high risk of abnormal delivery;~~
 - iii) ~~Operate a designated 24-hour per day emergency referral site with a defined practice for the care of obstetric emergencies;~~
 - iv) ~~Have an established program of services for the treatment of substance-abusing pregnant women;~~
 - v) ~~Integrate an accredited obstetrical residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved high-risk pregnant women; and~~
 - vi) ~~Operate organized ambulatory clinics for pregnant women that are easily accessible to the medically underserved.~~

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- ~~C) Clinics described in subsection (f)(1)(D) must:~~
- ~~i) Provide primary and specialty services for children demonstrating the need for extensive health care services due to a chronic condition as described in Section 140.462(e)(3)(C);~~
 - ~~ii) Operate a designated 24-hour per day emergency referral site with a defined practice for the care of pediatric emergencies;~~
 - ~~iii) Provide access to necessary pediatric primary and specialty services within 24 hours after referral;~~
 - ~~iv) Be a distinct department of a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120(a)(5);~~
 - ~~v) Integrate an accredited pediatric or family practice residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved children with specialty needs; and~~
 - ~~vi) Operate organized ambulatory clinics for children that are easily accessible to the medically underserved.~~
- 4) **Data Requirements**
~~The Maternal and Child Health clinics described in subsection (f)(1) shall be required to submit patient level historical data to the Department, which may include, but shall not be limited to historical data on the use of the hospital emergency room department.~~
- 5) **Certification Requirements**
~~Certification of qualifying status of a Maternal and Child Health clinic identified in subsection (f)(1) shall occur annually during the first two years of participation and every other year thereafter. In addition:~~
- ~~A) The certification process shall consist of a review of the completed~~

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~~application and related materials to determine provisional certification status. Those centers submitting approved applications shall then be reviewed on-site by Department staff within 60 days after application approval. Final notification of certification status shall be rendered within 30 days after the site review, pending provider submittal of a written plan of correction for any deficiencies discovered during the entire application process.~~

- ~~B) Entities interested in becoming a Maternal and Child Health clinic must direct a written request for an application packet to the following address:~~

~~Maternal and Child Health Clinic Certification
Bureau of Comprehensive Health Services
Illinois Department of Public Aid
201 South Grand Avenue East, Concourse
Springfield, Illinois 62763-0001~~

- ~~C) Certification status shall be suspended for Maternal and Child Health clinics identified in subsection (f)(1) that do not submit data to the Department, as required under subsection (f)(4), within 180 days after the Department's request for the submittal of such data.~~

- fg) School Based/Linked Health Clinics (centers) must be certified by the Department of Human Services (DHS) that they are meeting the minimum standards established by DHS (77 Ill. Adm. Code 2200). Examples of certification requirements include:

- 1) School based health centers must be located in schools or on school grounds, serving at least the students attending that school.
- 2) School linked health centers are located off school grounds, but a formal relationship must exist to serve students attending a particular school or multiple schools within the district.
- 3) All medical services performed by mid-level practitioners (i.e., medical services providers who are not physicians), such as nurse practitioners ~~(see~~

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~~Section 140.400~~, must be under the direction of a physician.

- 4) The center must have a medical director. The medical director of the center must be a qualified physician, licensed in Illinois to practice medicine in all its branches. Each center's medical director must develop standing orders and protocols for services provided at the center. The medical director shall ensure compliance with the policies and procedures pertaining to medical procedures and health care services. The medical director shall supervise the medical protocols involving direct care of students. The center must have consultant or back-up physicians with hospital admitting privileges. The consultant provider of the clinic for obstetrical care, as appropriate, must have delivery privileges. All medical services must be delivered in accordance with the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Practice Guidelines and the standards established by outside regulatory agencies.
- 5) All laboratory services must be in compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (42 USC 263a). DHS will provide ongoing monitoring to assure that appropriate standards are followed.
- 6) The center shall be staffed by Illinois licensed, registered, and/or certified health professionals who are trained and experienced in community and school health, and who have knowledge of health promotion and illness prevention strategies for children and adolescents. The center must ensure that staff are assigned responsibilities consistent with their education and experience, supervised, evaluated annually and trained in the policies and procedures of the center.
- 7) The center must establish procedures for the availability of primary care providers and for 24-hour per day, 12-month per year access to routine, urgent and emergency care, telephone appointments and advice. The center must have in place telephone answering methods that notify students and parents/guardians where and how to access 24-hour back-up services when the center is not open.
- 8) Services may be provided to eligible students who have obtained written

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parental consent, or who are 18 years of age, and/or who are otherwise able to give their own consent.

- 9) The center must coordinate care and the exchange of information necessary for the provision of health care of the student, between the center and a student's primary care practitioner, medical specialist or managed care entity. Written policies must address obtaining student and/or parental consent to share information regarding a student's health care.
- 10) The center must operate in accordance with a systematic process for referring students to community-based health care providers when the center is not able to provide the services required by the student. The center may provide medical care to a Managed Care Entity (MCE) enrolled student. The center shall refer that MCE enrolled student to the MCE primary care provider for continuing and definitive care.
 - A) The center shall refer a student who requires specialty medical and/or surgical services to his or her primary care provider or MCE to obtain a referral for a specialist.
 - B) The center shall document in the student's record that the referral was made, and document follow-up on the outcome of the referral when relevant to the health care provided by the center.
- 11) The center must develop a collaborative relationship with other health care providers, insurers, managed care organizations, the school health program, students and parents or guardians with the goal of assuring continuity of care, pertinent medical record sharing and reducing duplication and fragmentation of services.
- 12) **Data Requirements**
The center shall maintain a health record system that provides for consistency, confidentiality, storage and security of records for documenting significant student health information and the delivery of health care services.

| gh) Hospital Outpatient Departments

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Hospital outpatient departments may include facilities that meet the requirements of subsection (a)(3) of this Section.

- h) County-operated Outpatient Facilities
A county-operated outpatient facility is a non-hospital-based clinic operated by and located in an Illinois county with a population exceeding three million.
- 1) Critical Clinic Providers. A critical clinic provider is a county-operated outpatient facility that is within or adjacent to a large public hospital as defined in 89 Ill. Adm. Code 148.25(a)(1).
- 2) County Ambulatory Health Centers. A county ambulatory health center is a county-operated outpatient facility that is not a critical clinic provider.
- 3) County-operated outpatient facilities shall submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

(Source: Amended at 38 Ill. Reg. 15081, effective July 2, 2014)

Section 140.462 Covered Services in Clinics

Payment shall be made to clinics for the following types of services when provided by, or under the direction of, a physician:

- a) Hospital-Based Organized Clinics
- ~~1) With respect to those hospital-based organized clinics that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), covered services are those described in subsection (e), as appropriate.~~
- ~~12) Covered~~ With respect to all other hospital-based organized clinics, covered services are those described in 89 Ill. Adm. Code 148.
- ~~23) Group psychotherapy services~~ meeting must meet the guidelines set forth in Section 140.413(a)(4)(C).
- b) Encounter Rate Clinics

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- 1) With respect to those encounter rate clinics that qualify as Maternal and Child Health providers, as described in Section 140.924~~(a)(2)(B)~~, covered services are those described in Section 140.922.
 - 2) With respect to all other encounter rate clinics, covered services are medical services that provide for the continuous health care needs of persons who elect to use this type of service, including dental services that will be billed as separate encounters for dates of service on or after January 1, 2011.
 - 3) Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).
- c) Rural Health Clinics
Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:
- 1) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).
 - 2) Other services for which a separate encounter may be billed include dentist and behavioral health services as defined in Section 140.463(a).
 - 3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice that have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:
 - A) medical case management;
 - B) laboratory services;
 - C) occupational therapy;
 - D) patient transportation;

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- E) pharmacy services;
 - F) physical therapy;
 - G) podiatric services;
 - H) speech and hearing services;
 - I) x-ray services;
 - J) health education;
 - K) nutrition services;
 - L) optometric services.
- 4) A rural health clinic (RHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service provided.
- 5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing prior to billing for the services.
- 6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any RHC services with the exception of services identified in subsections (c)(7) and (c)(8).
- 7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an RHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

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- A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;
 - B) The RHC must be listed as the payee on the claim;
 - C) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;
 - D) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.
- 8) Effective July 1, 2013, an RHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:
- A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;
 - B) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;
 - C) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.
- d) Federally Qualified Health Centers
Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:
- 1) Physician's services, including covered services of nurse midwives, nurse practitioners and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).
 - 2) Other services for which separate encounters may be billed include

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dentists and behavioral health services as defined in Section 140.463(a).

- 3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:
 - A) medical case management;
 - B) laboratory services;
 - C) occupational therapy;
 - D) patient transportation;
 - E) pharmacy services;
 - F) physical therapy;
 - G) podiatric services;
 - H) optometric services;
 - I) speech and hearing services;
 - J) x-ray services;
 - K) health education;
 - L) nutrition services.
- 4) A federally qualified health center (FQHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service.
- 5) Any service that is no longer provided on or after October 1, 2001, or any

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new service added on or after October 1, 2001, must be communicated to the Department in writing.

- 6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any FQHC services provided with the exception of services identified in subsections (d)(7) and (d)(8).
- 7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an FQHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:
 - A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;
 - B) The FQHC must be listed as the payee on the claim;
 - C) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;
 - D) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.
- 8) Effective July 1, 2013, an FQHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:
 - A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;
 - B) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

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- C) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

e) ~~Maternal and Child Health Clinics~~

~~Payment shall be made to the Maternal and Child Health clinics identified in Section 140.461(f)(1) for the following services when provided by, or under the direction of, a physician:~~

- 1) ~~In the case of clinics described in Section 140.461(f)(1)(A) and (f)(1)(B), primary care services delivered by the clinic, which must include, but are not necessarily limited to:~~
- ~~A) Early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;~~
 - ~~B) Childhood risk assessments to determine potential need for mental health and substance abuse assessment and/or treatment;~~
 - ~~C) Regular immunizations for the prevention of childhood diseases;~~
 - ~~D) Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as a result of an EPSDT screening;~~
 - ~~E) Routine prenatal care, including risk assessment, for pregnant women; and~~
 - ~~F) Specialty care as medically needed.~~
- 2) ~~In the case of clinics described in Section 140.461(f)(1)(C), primary care and specialty services delivered by the clinic, which must include, but are not necessarily limited to:~~
- ~~A) Prenatal care, including risk assessment (one risk assessment per pregnancy);~~
 - ~~B) All ambulatory treatment services deemed medically necessary, recommended, or prescribed by a physician as the result of the~~

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- ~~assessment; and~~
- ~~C) Services to pregnant women with diagnosed substance abuse or addiction problems.~~
- ~~3) In the case of clinics described in Section 140.461(f)(1)(D):~~
- ~~A) Comprehensive medical and referral services.~~
- ~~B) Primary care services, which must include, but are not necessarily limited to:~~
- ~~i) early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;~~
- ~~ii) regular immunizations for the prevention of childhood diseases; and~~
- ~~iii) follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as the result of an EPSDT screening.~~
- ~~C) Pediatric specialty services, which must include, at a minimum, necessary treatment for:~~
- ~~i) asthma;~~
- ~~ii) congenital heart disease;~~
- ~~iii) diabetes; and~~
- ~~iv) sickle cell anemia.~~
- ~~D) Ambulatory treatment for other medical conditions as specified in the center's certificate application and as approved by the Department.~~
- ef) School Based/Linked Health Clinics (Centers)

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Covered services are the following services, when delivered in a school based/linked health center setting as described in Section 140.461 ~~(f)~~(g):

- 1) Basic medical services: well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance; immunizations; EPSDT services; diagnosis and treatment of acute illness and injury; basic laboratory tests; prescriptions and dispensing of commonly used medications for identified health conditions, in accordance with Medical Practice and Pharmacy Practice Acts; and acute management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.
- 2) Reproductive health services: gynecological exams; diagnosis and treatment of sexually transmitted diseases; family planning; prescribing and dispensing of birth control or referral for birth control services; pregnancy testing; treatment or referral for prenatal and postpartum care; and cancer screening.

(Source: Amended at 38 Ill. Reg. 15081, effective July 2, 2014)

Section 140.464 Hospital-Based and Encounter Rate Clinic Payments

- a) Hospital-based organized clinics, Hospital-Based Organized Clinics as described in Section 140.461(a), shall be paid in accordance with 89 Ill. Adm. Code 148.140.
 - ~~1) With respect to those hospital-based organized clinics, as described at Section 140.461(a), that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), payment shall be in accordance with Section 140.930.~~
 - ~~2) With respect to all other hospital-based organized clinics, payment shall be in accordance with 89 Ill. Adm. Code 148.140.~~
- b) Encounter Rate Clinics
 - 1) For encounter rate clinics, as described at Section 140.461(b), providing

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comprehensive health care for infants and women, including but not limited to prenatal and postnatal care, payment shall be made at the lesser of:

- A) \$90 per encounter; or
 - B) The clinic's charge to the general public.
- 2) For encounter rate clinics, as described at Section 140.461(b), providing dental services, payment shall be made at the lesser of:
- A) \$85 per encounter; or
 - B) The clinic's historical annual cost per encounter as calculated for a Federally Qualified Health Center (FQHC) in accordance with Section 140.463(b)(3)(B).
- 3) For all other encounter rate clinics, payment shall be made at the lesser of:
- A) The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or
 - B) \$50 per encounter; or
 - C) The clinic's charge to the general public.

c) County-Operated Outpatient Facilities

- 1) For critical clinic providers, as described in Section 140.461(h)(1), reimbursement for all services, including pharmacy-only-encounters, provided shall be on an all-inclusive per day 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.

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- 2) For county ambulatory health centers, the final rate is determined as follows:
- A) Base Rate. The base rate shall be the rate 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 (c)(2)(A)(i), 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 (c)(2)(A)(ii), shall be added to the resulting quotient, as calculated in subsection (c)(2)(A)(i), to determine the per encounter base rate.
 - iv) The resulting sum, as calculated in subsection (c)(2)(A)(iii), shall be the 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 (c)(2)(B)(i) shall be added to the product derived in subsection (c)(2)(B)(ii) to determine the per encounter supplemental rate.
 - iv) The resulting sum, as described in subsection (c)(2)(B)(iii), shall be the supplemental rate.

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- C) Final Rate. The final rate shall be the sum of the base rate and the supplemental rate.

(Source: Amended at 38 Ill. Reg. 15081, effective July 2, 2014)

SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

Section 140.930 Reimbursement

a) Reimbursement Rates for Maternal and Child Health Providers

- ~~1)~~ ~~Participating providers described in Section 140.924(a)(1) will receive enhanced rates for certain medical services specified in Table M of this Part. The enhanced rates are effective for services provided on or after April 1, 1993.~~
- ~~12)~~ Participating FQHCFQHC's, as described in Section 140.461(d), that meet the criteria specified in 140.924(a)(2)(A), shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.
- ~~23)~~ Participating encounter rate clinics shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.
- ~~4)~~ ~~Participating Maternal and Child Health clinics, as described in Sections 140.924 and 140.461(f), will receive enhanced rates for certain medical services specified in Table M of this Part. The enhanced rates are effective for services provided on or after April 1, 1993.~~
- ~~35)~~ Participating providers described in Section 140.924(a)(1) shall be eligible to receive a Well Child Visit Incentive Payment.
- A) The provider will receive a one time annual payment of \$30 for each qualifying child.

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- B) A qualifying child is a child who had its first, second, third, fourth or fifth birthday during the calendar year and for whom the provider personally, or through an affiliated provider, rendered all recommended well child visits, as described in Section 140.488.
- C) Recommended services must be rendered during the 13-month period ending one month after the child's birthday. For children turning one year old, the period begins ten days after birth and ends one month after the child's birthday. Rendering of services will be based on Department claims data.
- D) ~~Payments~~~~The first incentive payments shall be made by June 30, 2007 for children who met the definition of a qualifying child during calendar year 2005.~~ Subsequent payments will be made at least annually.
- E) For the purpose of payments under this Section, "affiliated provider" shall mean providers designated pursuant to Section 140.994.
- i) ~~For qualifying children during calendar year 2005 through 2007, a provider with the same payee in accordance with Section 140.24(d).~~
- ii) ~~For qualifying children during calendar year 2008 and later, providers designated pursuant to Section 140.994.~~
- b) Patient Management Fee
Providers who have accepted primary care responsibilities for foster children residing in Cook County who are under the guardianship of the Department of Children and Family Services will receive a monthly patient management fee for each client enrolled with them.
- c) Case Management Services
Providers of case management services will receive monthly payments. The payments will be prorated based upon an annual amount per case.

(Source: Amended at 38 Ill. Reg. 15081, effective July 2, 2014)

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Section 140. TABLE J Rate Regions~~HSA Grouping (Repealed)~~

These geographic regions, comprised of counties, are used in various rate methodologies and are defined as follows:

Region 1 – NorthwesternIllinois Counties:

<u>Boone</u>	<u>Bureau</u>	<u>Carroll</u>	<u>DeKalb</u>	<u>Fulton</u>
<u>Henderson</u>	<u>Henry</u>	<u>JoDaviess</u>	<u>Knox</u>	<u>LaSalle</u>
<u>Lee</u>	<u>Marshall</u>	<u>Mercer</u>	<u>Ogle</u>	<u>Peoria</u>
<u>Putnam</u>	<u>Rock Island</u>	<u>Stark</u>	<u>Stephenson</u>	<u>Tazewell</u>
<u>Warren</u>	<u>Whiteside</u>	<u>Winnebago</u>	<u>Woodford</u>	

Out-of-State Counties:

<u>Des Moines IA</u>	<u>Clinton IA</u>	<u>Dubuque IA</u>	<u>Johnson IA</u>	<u>Scott IA</u>
<u>Dane WI</u>	<u>Green WI</u>	<u>Rock WI</u>	<u>Grant WI</u>	<u>LaFayette WI</u>
<u>Jackson IA</u>	<u>Muscatine IA</u>	<u>Louisa IA</u>		

Region 2 – CentralIllinois Counties:

<u>Adams</u>	<u>Brown</u>	<u>Calhoun</u>	<u>Cass</u>	<u>Champaign</u>
<u>Christian</u>	<u>Clark</u>	<u>Coles</u>	<u>Cumberland</u>	<u>DeWitt</u>
<u>Douglas</u>	<u>Edgar</u>	<u>Ford</u>	<u>Greene</u>	<u>Hancock</u>
<u>Iroquois</u>	<u>Jersey</u>	<u>Livingston</u>	<u>Logan</u>	<u>Macon</u>
<u>Macoupin</u>	<u>Mason</u>	<u>McDonough</u>	<u>McLean</u>	<u>Menard</u>
<u>Montgomery</u>	<u>Morgan</u>	<u>Moultrie</u>	<u>Piatt</u>	<u>Pike</u>
<u>Sangamon</u>	<u>Schuyler</u>	<u>Scott</u>	<u>Shelby</u>	<u>Vermilion</u>

Out-of-State Counties:

<u>Marion IN</u>	<u>Vigo IN</u>	<u>Marion MO</u>	<u>Clark MO</u>	<u>Lewis MO</u>
<u>Ralls MO</u>	<u>Pike MO</u>	<u>Lincoln MO</u>	<u>Newton IN</u>	<u>Benton IN</u>
<u>Warren IN</u>	<u>Vermillion IN</u>			

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Region 3 – SouthernIllinois Counties:

<u>Alexander</u>	<u>Bond</u>	<u>Clay</u>	<u>Clinton</u>	<u>Crawford</u>
<u>Edwards</u>	<u>Effingham</u>	<u>Fayette</u>	<u>Franklin</u>	<u>Gallatin</u>
<u>Hamilton</u>	<u>Hardin</u>	<u>Jackson</u>	<u>Jasper</u>	<u>Jefferson</u>
<u>Johnson</u>	<u>Lawrence</u>	<u>Madison</u>	<u>Marion</u>	<u>Massac</u>
<u>Monroe</u>	<u>Perry</u>	<u>Pope</u>	<u>Pulaski</u>	<u>Randolph</u>
<u>Richland</u>	<u>St. Clair</u>	<u>Saline</u>	<u>Union</u>	<u>Wabash</u>
<u>Washington</u>	<u>Wayne</u>	<u>White</u>	<u>Williamson</u>	

Out-of-State Counties:

<u>Vanderburgh IN</u>	<u>McCracken KY</u>	<u>Cape Girardeau MO</u>	
<u>St. Louis MO</u>	<u>City of St. Louis MO</u>	<u>St. Charles MO</u>	<u>Jefferson MO</u>
<u>Gibson IN</u>	<u>Ste. Genevieve MO</u>	<u>Perry MO</u>	<u>Scott MO</u>
<u>Mississippi MO</u>	<u>Posey KY</u>	<u>Livingston KY</u>	<u>Crittenden KY</u>
<u>Union KY</u>	<u>Sullivan IN</u>	<u>Knox IN</u>	

Region 4 – Cook CountyCookRegion 5 – Collar CountiesIllinois Counties:

<u>DuPage</u>	<u>Grundy</u>	<u>Kane</u>	<u>Kankakee</u>	<u>Kendall</u>
<u>Lake</u>	<u>McHenry</u>	<u>Will</u>		

Out-of-State Counties:

<u>Milwaukee County WI</u>	<u>Walworth WI</u>	<u>Kenosha WI</u>	<u>Lake IN</u>
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(Source: Old Table J repealed at 16 Ill. Reg. 19146, effective December 1, 1992; new Table J added at 38 Ill. Reg. 15081, effective July 2, 2014)

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**Section 140. TABLE M Enhanced Rates for Maternal and Child Health Provider Services
(Repealed)**

- a) ~~In accordance with Sections 140.464 and 140.930(a), certain providers who serve women will receive enhanced reimbursement rates for the following services:~~

CODE	DESCRIPTION
W7359	Prenatal risk assessment
59409	Vaginal delivery
59410	Vaginal delivery
59500	C-section delivery
59514	C-section delivery
59515	C-section delivery

- b) ~~In accordance with Sections 140.464 and 140.930(a), certain providers who serve children under age 21 will receive enhanced reimbursement rates for the following services:~~

CODE	DESCRIPTION
W7018	Healthy kids screening-Chicago Downstate
W7360	Risk assessment, child referred for mental health assessment/services
W7361	Risk assessment, for mental health services, child, no referral
W7362	Risk assessment, for child referred for substance abuse assessment/treatment
W7363	Risk assessment for substance abuse, child, no referral

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99201	Office visit—new patient—brief
99202	Office visit—new patient—limited
99203	Office visit—new patient—intermediate
99204	Office visit—new patient—extended
99205	Office visit—new patient—comprehensive
99211	Office visit—established patient—brief
99212	Office visit—established patient—limited
99213	Office visit—established patient—intermediate
99214	Office visit—established patient—extended
99215	Office visit—established patient—comprehensive

e) ~~All other visits and services billed under valid CPT-4 procedure codes will be reimbursed at January 1, 1993, rates.~~

(Source: Repealed at 38 Ill. Reg. 15081, effective July 2, 2014)

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- 1) Heading of the Part: Specialized Health Care Delivery Systems
- 2) Code Citation: 89 Ill. Adm. Code 146
- 3)

<u>Section Numbers:</u>	<u>Adopted Action:</u>
146.100	Amendment
146.105	Amendment
146.110	Amendment
146.115	Amendment
146.125	Amendment
146.130	Amendment
146.550	Amendment
146.840	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13].
- 5) Effective Date of Rule: July 2, 2014
- 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 rule, 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 21, 2014; 38 Ill. Reg. 4628 and March 21, 2014; 38 Ill. Reg. 6499
- 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 146.550 (a) of Section 146.550 at the beginning of the sentence add "Effective for dates of service on and after July 1, 2014," strike "Services" and add "services".

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In subsection 146.550(b) of Section 146.550, after "public" add "or" and change "\$610" to "\$683 and payments at this rate are exempt from the 2.7% rate deduction required under 305 ILCS 5/5-5".

In subsection 146.840(a) of Section 146.840 deleted "statewide" before the word "average".

In subsection 146.840(c) of Section 146.840 deleted "through 6.5 hours".

In subsection 146.840(d) of Section 146.840 deleted "statewide" before the word "average".

- 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 rule currently in effect? No
- 14) Are there any other rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform. These rules have also been modified based on negotiations for SB 741 of the 98th General Assembly which became effective June 16, 2014, as Public Act 98-651.
- 16) Information and questions regarding this adopted rule shall be directed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/782-1233

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

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CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMSPART 146
SPECIALIZED HEALTH CARE DELIVERY SYSTEMS

SUBPART A: AMBULATORY SURGICAL TREATMENT CENTERS

Section	
146.100	General Description
146.105	Definitions
146.110	Participation Requirements
146.115	Records and Data Reporting Requirements
146.125	Covered Ambulatory Surgical Treatment Center Services
146.130	Reimbursement for Services

SUBPART B: SUPPORTIVE LIVING FACILITIES

Section	
146.200	General Description
146.205	Definitions
146.210	Structural Requirements
146.215	SLF Participation Requirements
146.220	Resident Participation Requirements
146.225	Reimbursement for Medicaid Residents
146.230	Services
146.235	Staffing
146.240	Resident Contract
146.245	Assessment and Service Plan and Quarterly Evaluation
146.250	Resident Rights
146.255	Discharge
146.260	Grievance Procedure
146.265	Records and Reporting Requirements
146.270	Quality Assurance Plan
146.275	Monitoring
146.280	Non-Compliance Action
146.285	Voluntary Surrender of Certification
146.290	Geographic Groups

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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 and VI and 12-13].

SOURCE: Old Part repealed at 14 Ill. Reg. 13800, effective August 15, 1990; new Part adopted at 20 Ill. Reg. 4419, effective February 29, 1996; emergency amendment at 21 Ill. Reg. 13875, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 4430, effective February 27, 1998; emergency amendment at 22 Ill. Reg. 13146, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19914, effective October 30, 1998; amended at 23 Ill. Reg. 5819, effective April 30, 1999; emergency amendment at 23 Ill. Reg. 8256, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13663, effective November 1, 1999; amended at 24 Ill. Reg. 8353, effective June 1, 2000; emergency amendment at 26 Ill. Reg. 14882, effective October 1, 2002, for a maximum of 150 days; amended at 27 Ill. Reg. 2176, effective February 1, 2003; emergency amendment at 27 Ill. Reg. 10854, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18671, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 12218, effective August 11, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 14214, effective October 18, 2004, for a maximum of 150 days; amended at 29 Ill. Reg. 852, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2014, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 4360, effective March 7, 2005; expedited correction at 29 Ill. Reg. 14127, effective March 7, 2005; amended at 29 Ill. Reg. 6967, effective May 1, 2005; amended at 29 Ill. Reg. 14987, effective September 30, 2005; amended at 30 Ill. Reg. 8845, effective May 1, 2006; amended at 31 Ill. Reg. 5589, effective April 1, 2007; emergency amendment at 31 Ill. Reg. 5876, effective April 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11681, effective August 1, 2007; amended at 33 Ill. Reg. 11803, effective August 1, 2009; emergency amendment at 36 Ill.

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Reg. 6751, effective April 13, 2012, for a maximum of 150 days; amended at 36 Ill. Reg. 13885, effective August 27, 2012; amended at 37 Ill. Reg. 17624, effective October 28, 2013; expedited correction at 38 Ill. Reg. 4518, effective October 28, 2013; amended at 38 Ill. Reg. 13255, effective June 11, 2014; amended at 38 Ill. Reg. 13893, effective June 23, 2014; amended at 38 Ill. Reg. 15152, effective July 2, 2014.

SUBPART A: AMBULATORY SURGICAL TREATMENT CENTERS

Section 146.100 General Description

This Part sets forth the conditions that an ambulatory surgical treatment center must meet in order to participate in the [Medical Assistance](#)~~Medicaid~~ Program.

(Source: Amended at 38 Ill. Reg. 15152, effective July 2, 2014)

Section 146.105 Definitions

For purposes of this Part, the following terms shall be defined as follows:

- a) "Ambulatory Surgical Treatment Center" ~~or "(ASTC)".~~ Any distinct entity that operates primarily for the purpose of providing surgical services to patients not requiring hospitalization. Such facilities shall not provide beds or other accommodations for the overnight stay of patients; however, facilities devoted exclusively to the treatment of children may provide accommodations and beds for their patients for up to 23 hours following admission. Individual patients shall be discharged in an ambulatory condition without danger to the continued well-being of the patients or shall be transferred to a hospital or other similar environment. This provision shall include any place which meets the definition of an ambulatory surgical treatment center under the regulations of the [Centers for Medicare and Medicaid Services](#)~~Federal Health Care Financing Administration~~ (42 CFR 416). The term "ambulatory surgical treatment center" does not include:
 - 1) Any institution, place, building or agency required to be licensed pursuant to the Hospital Licensing Act [210 ILCS 85].~~;~~
 - 2) Any person or institution required to be licensed pursuant to the Nursing Home Care Act [210 ILCS 45], [the ID/DD Community Care Act \[210 ILCS 47\]](#), [or the Specialized Mental Health Rehabilitation Act of 2013](#)

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[210 ILCS 49].;

- 3) Hospitals or ambulatory surgical treatment centers maintained by the State or any department or agency thereof, where such department or agency has authority under law to establish and enforce standards for the hospitals or ambulatory surgical treatment centers under its management and control.;
 - 4) Hospitals or ambulatory surgical treatment centers maintained by the federal government or agencies thereof.;
 - 5) Any place, agency, clinic or practice, public or private, whether organized for profit or not, devoted exclusively to the performance of dental or oral surgical procedures.
- b) "Ambulatory Surgical Treatment Center Services." Facility services that are furnished in an ambulatory surgical treatment center.
 - c) "Department." The Illinois Department of Healthcare and Family Services ~~Public Aid~~.
 - d) "Facility Services." Services that are furnished in connection with covered surgical procedures performed in an ambulatory surgical treatment center.

(Source: Amended at 38 Ill. Reg. 15152, effective July 2, 2014)

Section 146.110 Participation Requirements

To participate in the Medical Assistance ~~Medicaid~~ Program, an ambulatory surgical treatment center (ASTC) must, in addition to any other Department requirements:

- a) Be licensed by the Illinois Department of Public Health pursuant to 77 Ill. Adm. Code 205.
- b) In the case of an out-of-state ASTC, be licensed by ~~the~~ ~~their~~ state in which it is located ~~agency~~ or, where a state does not license ASTCs, be accredited by a national accrediting body.

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- c) Meet the requirements in 42 CFR 416.
- d) Maintain a contractual relationship, including a transfer and referral plan with a hospital. Such a plan shall include procedures for effecting transfer of the patient from the ASTC to a hospital.
 - 1) The contracting hospital must be within 15 minutes of the ASTC.
 - 2) Have an effective procedure for the immediate transfer to a hospital of patients requiring emergency medical care beyond the capabilities of the ASTC.
- e) Ensure that a qualified physician shall be present at the facility at all times during the operative and postoperative period for all patients.
- f) Must perform surgical procedures in a safe manner using qualified physicians or dentists who have been granted clinical privileges by the governing body of the ASTC. These providers must be licensed in the State of Illinois or, for an out-of-state ASTC, licensed by the state in which they practice and have skilled equivalent practice privileges at a licensed hospital.

(Source: Amended at 38 Ill. Reg. 15152, effective July 2, 2014)

Section 146.115 Records and Data Reporting Requirements

- a) In addition to any other Department record requirements, the ambulatory surgical treatment center (ASTC) must maintain complete, comprehensive and accurate medical records to ensure adequate patient care that includes, but is not limited to, the following:
 - 1) Patient identification.⚠
 - 2) Significant medical history and results of physical examination.⚠
 - 3) Preoperative diagnostic studies (entered before surgery), if performed.⚠
 - 4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the

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- governing body of the ASTC or ~~State~~ law.
- 5) Any known allergies and abnormal drug reactions.
 - 6) Entries related to anesthesia administration.
 - 7) Documentation of properly executed informed patient consent.
 - 8) Discharge diagnosis, ~~and~~
 - 9) Medications ordered and administered.
- b) ASTC medical records must contain the dates of service and the name of the medical practitioner seeing the patient at the time of each center visit.
- c) Medical records for ~~Medical Assistance~~ ~~Medicaid~~ patients must be made available to the Department or its designated representative in the performance of utilization review.
- d) The ASTC agrees to furnish to the Department, if requested, information necessary to establish payment rates in the form and manner that the Department requires.
- e) Services provided in an ASTC may be subject to prepayment and post-payment review to assess medical care, coding validation and quality of care.

(Source: Amended at 38 Ill. Reg. 15152, effective July 2, 2014)

Section 146.125 Covered Ambulatory Surgical Treatment Center Services

Effective for dates of service on or after July 1, 2014:

- a) The Department of Healthcare and Family Services will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered enhanced ambulatory patient group (EAPG) services as defined in 89 Ill. Adm. Code 148.140(b)(1); Ambulatory Procedure Listing (APL) Groupings, as defined in 89 Ill. Adm. Code 148.140(b)(1). The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in

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a hospital setting.

- b) Facility services furnished by an ASTC in connection with covered APL codes include, but are not limited to:
- 1) Nursing, technician and related services.;
 - 2) Use of the ASTC facilities.;
 - 3) Supplies (such as drugs, ~~biological products (e.g., blood)~~biologicals (for example, blood)), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of surgical procedures.;
 - 4) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.;
 - 5) Administrative, record keeping, and housekeeping items and services.;
 - 6) Materials for anesthesia.
- c) Facility services do not include items and services for which payment may be made under other provisions of this Section such as physicians' or dentists' services, laboratory, x-ray or diagnostic procedures performed by independent facilities or practitioners on the day of surgery (other than those directly related to performance of the surgical procedure), prosthetic devices, ambulance services, leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home. In addition, they do not include anesthetist services.

(Source: Amended at 38 Ill. Reg. 15152, effective July 2, 2014)

Section 146.130 Reimbursement for Services

Effective for dates of service on or after July 1, 2014:

- a) With respect to all ~~non-EAPG~~~~non-APL~~ procedures, reimbursement levels shall be at the lower of the ASTC's usual and customary charge to the public or the Department's Statewide maximum reimbursement screen.

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- b) With respect to ~~EAPGAPL~~ procedures described in 89 Ill. Adm. Code 148.140(b)(1), reimbursement for ~~those such~~ services shall be in accordance with an all-inclusive rate for facility services, and shall be calculated at 75 percent of the applicable group rate paid for that same procedure in a hospital outpatient setting, as described under 89 Ill. Adm. Code 148.140~~(d)(7)(b)~~.
- c) Laboratory, x-ray, prescription, physician physicians' or dental dentists' services, provided in connection with a covered surgical procedure, must be billed by the providers rendering ~~those such~~ services. If the ASTC provides the ~~laboratory lab~~ or x-ray service, then:
- 1) Separate billing is NOT allowed if provided on the day of surgery; or
 - 2) Separate billing IS allowed if provided on other than the day of surgery.
- d) The providers described in subsection (c) ~~of this Section~~ must meet all applicable license, enrollment and reimbursement conditions of the Department of Healthcare and Family Services, the Department of Public Health and the Department of Financial and Professional Regulation-Division of Professional Regulation.

(Source: Amended at 38 Ill. Reg. 15152, effective July 2, 2014)

SUBPART D: CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTERS

Section 146.550 Reimbursement for Services

- a) Effective for dates of service on and after July 1, 2014, services ~~Services~~ provided under Section 146.540(a)(1) shall be reimbursed in accordance with 89 Ill. Adm. Code 140.474(c).
- b) Services provided under Section 146.540(a)(2) shall be reimbursed on a per diem basis at the lower of the Children's Community-Based Health Care Center's usual and customary charge to the public or at the Department's rate of \$683 and payments at this rate are exempt from the 2.7% rate reduction required under 305 ILCS 5/5-5e, ~~or half of the default children's hospital base rate rounded to the nearest whole dollar as defined in 89 Ill. Adm. Code 148.270(e)(5)(B).~~

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- c) Services provided under Section 146.540(b)(1) shall be reimbursed in accordance with 89 Ill. Adm. Code 140.474(c).
- d) Services provided under Section 146.540(b)(2) shall be reimbursed at the Department's rate of \$17 per hour.
- e) Effective for dates of service on or after July 1, 2012, reimbursement rates paid under this Section shall be reduced by 2.7% from the rates in effect on June 30, 2012.

(Source: Amended at 38 Ill. Reg. 15152, effective July 2, 2014)

SUBPART F: BIRTH CENTERS

Section 146.840 Reimbursement of Birth Center Services

- a) Facility services provided by a birth center located in Cook County will be reimbursed at the lower of billed charges or 75 percent of the average facility payment rate made to a hospital located in Cook County for an uncomplicated vaginal birth.
- b) Facility services provided by a birth center located outside of Cook County will be reimbursed at the lower of billed charges or 75 percent of the statewide average facility payment rate made to a hospital located outside of Cook County for an uncomplicated vaginal birth.
- c) Observation services will be reimbursed at the lower of billed charges or at 75 percent of the rate established by the Department for the number of hours of observation billed pursuant to 89 Ill. Adm. Code 148.140(b)(1)(D) as reflected at <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx> through dates of service on June 30, 2014. Effective for dates of service on or after July 1, 2014, observation services will be reimbursed at the lower of billed charges or \$53.56 for 1 hour or more.
- d) Transfer fees for a birth center located in Cook County will be reimbursed at the lower of billed charges or 15 percent of the average facility payment rate made to a hospital located in Cook County for an uncomplicated vaginal birth.

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- e) Transfer fees for a birth center located outside of Cook County will be reimbursed at the lower of billed charges or 15 percent of the statewide average facility payment rate made to a hospital located outside of Cook County for an uncomplicated vaginal birth.

(Source: Amended at 38 Ill. Reg. 15152, effective July 2, 2014)

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- 1) Heading of the Part: Hospital Services
- 2) Code Citation: 89 Ill. Adm. Code 148
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
148.20	Amendment
148.25	Amendment
148.30	Amendment
148.40	Amendment
148.50	Amendment
148.60	Amendment
148.70	Amendment
148.82	Amendment
148.85	Repeal
148.90	Repeal
148.95	Repeal
148.100	Amendment
148.103	Repeal
148.105	Amendment
148.110	Amendment
148.112	Amendment
148.115	Amendment
148.116	New Section
148.117	Amendment
148.120	Amendment
148.122	Amendment
148.126	Amendment
148.130	Amendment
148.140	Amendment
148.150	Amendment
148.160	Amendment
148.170	Amendment
148.175	Repeal
148.180	Amendment
148.200	Repeal
148.210	Amendment
148.220	Repeal
148.230	Repeal

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148.240	Amendment
148.250	Repeal
148.260	Repeal
148.270	Repeal
148.280	Repeal
148.290	Amendment
148.295	Amendment
148.296	Amendment
148.297	Amendment
148.298	Repeal
148.299	New Section
148.300	Amendment
148.310	Amendment
148.320	Repeal
148.330	Amendment
148.370	Amendment
148.390	Amendment
148.400	Amendment
148.436	Amendment
148.442	Amendment
148.446	Amendment
148.448	Amendment
148.450	Amendment
148.456	Amendment
148.458	Amendment
148.460	Repeal
148.462	Repeal
148.464	Amendment
148.468	Amendment
148.482	Amendment
148.860	Amendment
148.TABLE C	Amendment

- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Rule: July 2, 2014
- 6) Does this rulemaking contain an automatic repeal date? No

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- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rule, 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 21, 2014; 38 Ill. Reg. 4640 and March 21, 2014; 38 Ill. Reg. 6505
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: Sections 148.440, 148.444, 148.452, 148.454, 148.466, 148.470, 148.472, 148.474, 148.476, 148.478, 148.480, 148.484, and 148.486 appeared in the proposed rulemaking but have not been included in the adopted rulemaking. HFS originally proposed no amendments to these Sections other than adding a January 1, 2015, termination date for the supplemental payment provisions they contained. Since the sunset date has been removed in accordance with PA 98-651, these Sections will not undergo any change as a result of this rulemaking.

In subsection 148.25 (i) of Section 148.25 changed to read:

"Children's Specialty Hospital. To qualify as a children's specialty hospital, a facility must be:

- 1) an Illinois hospital as defined in subsection (d)(3)(A) and have fewer than 50 total inpatient beds; or
- 2) a cost reporting hospital, as defined in subsection (d)(3)(A), located outside of Illinois and have fewer than 50 total beds and an average length of stay greater than 20 days in State fiscal year 2013, as contained in the Department's claims data warehouse."

The provisions of various Sections were made effective for dates of discharge (rather than dates of service) on or after July 1, 2014.

In subsection 148.105(d)(2)(A)(i) of Section 148.105 changed the second bullet point to read as follows: "80 percent of the arithmetic mean rate for rehabilitation distinct part units."

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In subsection 148.105(f) of Section 148.105 the definition "Allocated static payments" is changed to read as follows: ""Allocated static payments" means the adjustment payments made to the hospital pursuant to 89 Ill. Adm. Code 148.105, 148.115, 148.126, 148.295, 148.296 and 148.298, during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies outlined in rule as of February 21, 2014 (see <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>), as determined by the Department, allocated to rehabilitation services based on the ratio of rehabilitation claim charges to total inpatient claim charges determined using inpatient base period claims data."

In subsection 148.110(c)(1) of Section 148.110 deleted "For which the Department had no inpatient base period paid claims data, shall be the product of" and added "For psychiatric hospitals not enrolled with the Department on June 30, 2014, shall be the product of".

In subsection 148.110(c)(2) of Section 148.110 deleted "For which the Department had inpatient base period paid claims data, shall be the product of" and added "For psychiatric hospitals enrolled with the Department on June 30, 2014, shall be the product of".

In subsection 148.110(e)(1) of Section 148.110 deleted "July 1, 2011" and added "June 30, 2014".

In subsection 148.110 of Part 148, added a new subsection 148.110(g) that states: "Psychiatric hospital adjustors for dates of service beginning July 1, 2014 through June 30, 2018. For Illinois freestanding psychiatric hospitals, defined in Section 148.25(d)(1), that were not children's hospitals as defined in Section 148.25(d)(3) in FY 2013 and whose Medicaid covered days were 90% or more for individuals under 20 years of age in FY 2013, the Department shall pay a per day add-on of \$48.25."

In subsection 148.110(f) of Section 148.110 deleted "148.117; and" from the definition of "Allocated static payments" and added after "in" "rule as of February 21, 2014" and closed parentheses after "aspx"

In subsection 148.115(e) of Section 148.115 deleted "148.117" and added "148.296" to the definition "Allocated static payments" and added after "in" "rule as of February 21, 2014 (see)" and closed parentheses after "aspx".

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In subsection 148.116(a) of Section 148.116 added after "Hospital" in the first line "located in Illinois"

In subsection 148.116(a)(3)(A) of Section 148.116 deleted "Section" and replaced with "subsection"

In subsection 148.116(b) of Section 148.116 added at the beginning of the sentence "For Children's specialty hospitals defined in 148.25(i)," and deleted "Hospital".

In subsection 148.116(c)(1) of Section 148.116 after "hospitals" added "located in Illinois" and deleted "difference" and added "product".

In subsection 148.116(c)(1)(A) of Section 148.116 changed the subsection to read as follow: "The amount of static payments made to the hospital in State fiscal year 2011 in accordance with 89 Ill. Adm. Code 148.126, 148.295, 148.296, 148.297 and 148.298 pursuant to the methodologies outlined in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>; and"

In subsection 148.116(c)(3) of Section 148.116 deleted "Section" and replaced with "subsection".

In subsection 148.116(d) of Section 148.116 deleted "2016" and replaced with "2018" in the first and second sentences.

In Section 148.116 added a new subsection 148.116 "(e)" to read as follows: "For cost reporting hospitals located outside of Illinois that meet the definition of a Children's specialty hospitals as defined in Section 148.25(i) as of 6/30/14, for inpatient general acute care and rehabilitation services, the hospital shall have a per diem amount equal to the rate in place with the Department as of June 30, 2014. The total payment for inpatient stay will equal the sum of the payment determined in this Subsection and any applicable adjustments to payments specified in Section 148.290."

In subsection 148.117(a)(14) of Section 148.117 undeleted the language that reads: "(a)(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

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outpatient ambulatory procedure listing services in the outpatient assistance base year." and it becomes the new "148.117(a)(11)".

In subsection 148.117(b)(2) of Section 148.117 the language is changed to read as follows: "For hospitals qualifying under subsection (a)(2), the rate is \$290.00 for dates of service on or after July 1, 2014."

In subsection 148.117(b)(3) of Section 148.117 the language is changed to read as follows: "For hospitals qualifying under subsection (a)(3), the rate is \$250.00 for dates of service on or after July 1, 2014."

In subsection 148.117(b)(4) of Section 148.117 the language is changed to read as follows: "For hospitals qualifying under subsection (a)(4), the rate is \$336.25 for dates of service on or after July 1, 2014."

In subsection 148.117(b)(5) of Section 148.117 the language is changed to read as follows: "For hospitals qualifying under subsection (a)(5), the rate is \$110.00 for dates of service on or after July 1, 2014."

In subsection 148.117(b)(6) of Section 148.117 the language is changed to read as follows: "For hospitals qualifying under subsection (a)(6), the rate is \$200.00 for dates of service on or after July 1, 2014."

In subsection 148.117(b)(7) of Section 148.117 the language is changed to read as follows: "For hospitals qualifying under subsection (a)(7), the rate is \$247.50 for dates of service on or after July 1, 2014."

In subsection 148.117(b)(8) of Section 148.117 the language is changed to read as follows: "For hospitals qualifying under subsection (a)(8), the rate is \$205.00 for dates of service on or after July 1, 2014."

In subsection 148.117(b)(9) of Section 148.117 the language is changed to read as follows: "For hospitals qualifying under subsection (a)(9), the rate is \$65.00 for dates of service on or after July 1, 2014."

In subsection 148.117(b)(10) of Section 148.117 the language is changed to read as follows: "For hospitals qualifying under subsection (a)(10), the rate is \$90.00 for dates of service on or after July 1, 2014."

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In subsection 148.117(b)(14) of Section 148.117 undeleted language and renumbered it as "148.117(b)(11)" and the language reads as follows: "For hospitals qualifying under subsection (a)(11), the rate is \$47.00 for dates of service on or after July 1, 2010."

In Section 148.117, deleted subsection 148.117 "(f)"

In subsection 148.120(i)(6)(A)(i)-(B)(ii) of Section 148.120 the language is changed to read as follows:

- "6) "Low income utilization rate" means a fraction, expressed as a percentage that is the sum of the amount resulting from the calculations in subsection (i)(6)(A) plus (i)(6)(B):
- A) The fraction (expressed as a percentage) –
 - i) the numerator of which is the sum of the total revenues paid the hospital for patient services under Medicaid State plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and the amount of the cash subsidies for patient services received directly from State and local governments, and
 - ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and
 - B) The fraction (expressed as a percentage) –
 - i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in subsection (6)(A)(i); and
 - ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period."

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In subsection 148.122(d)(3) of Section 148.122 deleted "2014" and added "2003 and annually thereafter".

In subsection 148.122(d)(3)(B) of Section 148.122 the language is changed to read as follow: "The percentage increase in the Statewide average hospital payment rate, over the previous year's Statewide average hospital payment rate."

In subsection 148.126(a)(10) of Section 148.126 undeleted the language and renumbered it as a new "148.126(a)(6)" and the language reads as follows:

"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)(5) 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."

In subsection 148.126(a)(6) through 148.126(a)(10) of Section 148.126, all renumbered to "(a)(7)" to "(a)(11)".

In subsection 148.126(a)(6)(A) of Section 148.126 is renumbered "(a)(7)(A)" and the language was changed to read as follows: "Does not already qualify under subsections (a)(1) through (a)(6) of this Section."

In subsection 148.126(a)(7)(A) of Section 148.126 is renumbered "(a)(8)(A)" and the language was changed to read as follows: "Does not already qualify under subsections (a)(1) through (a)(7) of this Section."

In subsection 148.126(a)(8)(A) of Section 148.126 is renumbered "(a)(9)(A)" and the language was changed to read as follows: "Does not already qualify under subsections (a)(1) through (a)(8) of this Section."

In subsection 148.126(a)(9) of Section 148.126 is renumbered "(a)(10)"

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In subsection 148.126(a)(10)(A) of Section 148.126 is renumbered "(a)(11)(A)" and the language was changed to read as follows: "Does not already qualify under subsections (a)(1) through (a)(10) of this Section."

In subsection 148.126(a)(20) of Section 148.126 undeleted language, renumbered as "148.126(a)(12)" and changed the language to read as follows:

- "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) 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."

In subsection 148.126(b)(1) of Section 148.126 changed the language to read as follows: "Provides obstetrical care - \$210.00 for dates of service on or after July 1, 2014."

In subsection 148.126(b)(2) of Section 148.126 changed the language to read as follows: "Does not provide obstetrical care - \$90.00 for dates of service on or after July 1, 2014."

In subsection 148.126(c) of Section 148.126 changed the language to read as follows: "For a hospital qualifying under subsection (a)(2), the rate shall be \$55.00 on or after July 1, 2014."

In subsection 148.126(d) of Section 148.126 changed the language to read as follows: "For a hospital qualifying under subsection (a)(3), the rate shall be \$3.00 on or after July 1, 2014."

In subsection 148.126(e) of Section 148.126 changed the language to read as follows: "For a hospital qualifying under subsection (a)(4), the rate shall be \$140.00 on or after July 1, 2014."

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In subsection 148.126(f) of Section 148.126 changed the language to read as follows:
"For a hospital qualifying under subsection (a)(5), the rate shall be \$119.50 on or after July 1, 2014."

In subsection 148.126(g) of Section 148.126 changed the language to read as follows:
"For a hospital qualifying under subsection (a)(7), the rate shall be \$221.00 on or after July 1, 2014."

In subsection 148.126(h) of Section 148.126 changed the language to read as follows:
"For a hospital qualifying under subsection (a)(8), the rate shall be \$100.00 on or after July 1, 2014."

In subsection 148.126(i) of Section 148.126 changed the language to read as follows:
"For a hospital qualifying under subsection (a)(9), the rate shall be \$69.00 on or after July 1, 2014. The reimbursement rate is contingent upon federal approval."

In subsection 148.126(j) of Section 148.126 changed "(a)(9)" to "(a)(10)", deleted "For dates of service on or after July 1, 2014 through December 31, 2014, the rate is \$56.00. For dates of services on or after January 1, 2015, the rate is \$0.00." and added "For dates of service on or after July 1, 2014, the rate is \$56.00."

In subsection 148.126(k) of Section 148.126 deleted "For a hospital qualifying under subsection (a)(10), the rate is \$84.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00." and added "For a hospital qualifying under subsection (a)(11) of this Section, the rate is \$197.00 on or after July 1, 2014."

In subsection 148.126 of Part 148 added a new "148.126(l)" to read as follows:
"For a hospital qualifying under subsection (a)(6) of this Section, the rate is \$25.00 on or after July 1, 2014."

In subsection 148.126 of Part 148 added a new "148.126(m)" to read as follows:
"For a hospital qualifying under subsection (a)(12) of this Section, the rate is \$71.00 on or after July 1, 2014."

In subsection 148.126(l) of Section 148.126 renumbered "(l)" to "(n)".

In subsection 148.126(m) of Section 148.126 renumbered "(m)" to "(o)".

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In subsection 148.126(n) of Section 148.126 renumbered "(n)" to "(p)".

In subsection 148.126(o)(8) change the "(m)" to "(o)"

In subsection 148.126(p) of Section 148.126 deleted "148.295(g)(5)" and replaced with "148.295(b)(5)" and deleted "six months" and added "60 days, unless extended by the Department in its sole discretion"

In subsection 148.140(a)(1)(B) of Section 148.140 deleted "(c)" and added "(g)"

In subsection 148.140(a)(1)(C) of Section 148.140 deleted language in its entirety: "Those services provided by a Critical Clinic Provider as described in subsection (e) of this Section."

In subsection 148.140(d)(4)(A) of Section 148.140 added "and freestanding emergency centers as defined in 148.25(e)" after "acute hospitals".

In subsection 148.140(d) of Section 148.140 added a new subsection "(d)(8)" to read as follows: "Out-of-state non-cost reporting hospital EAPG standardized amount. For non-cost reporting hospitals, the EAPG standardized amount is \$362.32."

Stricken text in 148.140(a)(1)(E) and 148.140(g) did not appear in the original proposed version, but was later added via an Expedited Correction effective December 27, 2010. This rulemaking permanently removes this language and replaces it with updated provisions for Freestanding Emergency Centers.

In subsection 148.140(f)(1)(C) of Section 148.140 deleted "1.3252" and added "1.3218".

In subsection 148.140(f)(3)(A) of Section 148.140 deleted "(f)(2)(C)" and added "(d)(4)".

In subsection 148.140(f)(2)(D) of Section 148.140 deleted "1.3252" and added "1.3218".

In subsections 148.140(g)(1) and 148.140(g)(2) of Section 148.140, deleted "1994" and added "2010"

In subsection 148.140(h) of Section 148.140 added the following language to the end: "Grouper shall be updated at least triennially and no more frequently than annually."

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In subsection 148.140(i) of Section 148.140 in the definition "High outpatient volume" deleted "services" and added "claims".

In subsection 148.140(i) of Section 148.140 in the "Definitions" "Medicare IPPS wage index" changed the language to read as follows: "means for in-state providers and out-of-state Illinois Medicaid cost reporting providers, the wage index used for inpatient reimbursement as described in 89 Ill. Adm. Code 149.100. For out-of-state non-cost reporting providers, the wage index used to adjust the EAPG standardized amount shall be a factor of 1.0."

In subsection 148.160(c) of Section 148.160 in the "Definitions" changed the language to read as follows: "Inpatient base period paid claims data" means Medicaid fee-for-service inpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period."

In subsection 148.160(c) of Section 148.160 in the "Definitions" changed the language to read as follows: "Outpatient base period paid claims data" means Medicaid fee-for-service outpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period, excluding crossover claims."

In subsection 148.170(c) of Section 148.170 under Definitions changed the following language to read as follows: "Inpatient base period claims data" means Medicaid fee-for-inpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period."

In subsection 148.170(c) of Section 148.170 under Definitions changed the following language to read as follows: "Outpatient base period claims data" means Medicaid fee-for-service outpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period, excluding crossover claims."

In subsection 148.210(d) of Part 148 deleted entire subsection (d) that read:

- "d) The assessment or license fees described in 89 Ill. Adm. Code 140, Subpart C, 140.82, 140.84, 140.94 and 140.95 may not be reported as allowable Medicaid costs on the Medicaid cost report."

In subsection 148.240(i)(1)(A)(i) of Section 148.240 added back in the word "care" following the word "patient".

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In subsection 148.295(a)(1) of Section 148.295 deleted "(c)" and added "(a)" to read as follows: "Hospitals may qualify for the DHA under this subsection (a)."

Subsection 148.295(a)(1)(D) of Section 148.295 is undeleted and amended to read as follows:

- "D) Illinois teaching hospitals, with more than 40 graduate medical education programs on July 1, 1999, not qualifying in subsection (a)(1)(A), (B) or (C) of this Section."

In subsection 148.295(a)(1)(D) of Section 148.295 renumbered to 148.295(a)(1)(E) and changed to read as follows:

"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 (a)(1)(A) through (a)(1)(D) 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."

In subsection 148.295(a)(2)(B) of Section 148.295 changed to read as follows: "Hospitals qualifying under subsection (a)(1)(A) with an average length of stay less than 3.9 days will continue to receive the rate in effect as of December 31, 2013, \$254.00 per day, for dates of service on or after July 1, 2014."

In subsection 148.295(a)(2)(E) of Section 148.295 changed to read as follows: "Hospitals qualifying under subsection (a)(1)(B) that have more than 1,500 obstetrical days will continue to receive the rate in effect as of December 31, 2013, \$224.00 per day, for dates of service on or after July 1, 2014."

In subsection 148.295(a)(2)(F) of Section 148.295 changed to read as follows: "Hospitals qualifying under subsection (a)(1)(C) that are not located in Illinois, have an MIUR greater than 45 percent, and greater than 4,000 days will continue to receive the rate in effect as of December 31, 2013, \$117.00 per day, for dates of service on or after July 1, 2014."

In subsection 148.295(a)(2)(G) of Section 148.295 changed the language to read as follows: "Hospitals qualifying under subsection (a)(1)(E) will continue to receive the rate

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in effect as of December 31, 2013, \$90.00 per day, for dates of service on or after July 1, 2014."

Added new subsection 148.295(a)(2)(H) in Section 148.295 to read as follows:
"Hospitals qualifying under subsection (a)(1)(D) of this Section with a combined MIUR that is equal to or greater than 35 percent will receive a rate of \$54.00 for dates of service on or after July 1, 2014."

In subsection 148.295(b)(5) in Section 148.295 added after "305 ILCS 5/5-30" the following: ",including an out of state hospital in a county contiguous to a managed care region."

In subsection 148.295(b)(5)(A) in Section 148.295 added after "services" "with one or more MCOs"

In subsection 148.295(b)(5)(B) in Section 148.295 added after "plan" "Has not been offered a contract by a care coordination plan that the Department has determined to be a good faith offer when the plan that pays not less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplement payment that the Department pays directly, except to the extent those adjustments or supplemental payments are incorporated into the development of the applicable MCO capitated rates."

In subsection 148.295(b)(5) in Section 148.295 added a new "D)" to read as follows: "As used in this subsection (b)(5), "MCO" means any entity that contracts with the Department to provide services when payment for medical services is made on a capitated basis."

In subsection 148.296(a) of Section 148.296 deleted "DRG PPS".

In subsection 148.296(a)(1)(A) of Section 148.296 deleted "Freestanding psychiatric rehabilitation, LTAC providers" and capitalized the word "University".

In subsection 148.296(a)(1)(B) of Section 148.296 deleted "DRG PPS".

In subsection 148.296(a)(2)(A) of Section 148.296 added "DSH payments" after the word "excluding".

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In subsection 148.296(a)(2)(F) of Section 148.296 deleted entire language that read as follows: "Estimated payment gain or loss percentage under the combined new inpatient and outpatient systems shall be determined as follows: (Estimated payment gain or loss) / [(Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments)]."

In subsection 148.296(b) of Section 148.296 changed language to read as follows: "Transitional Supplemental Payments for qualifying providers shall be equal to the estimated payment loss under the combined new inpatient and outpatient systems, as defined in subsection (a)(2)(E)."

In subsections 148.296 (b)(1) and 148.296(b)(2) of Section 148.296 delete language in its entirety that read as follows:

- "b) Transitional Supplemental Payments for qualifying providers shall be the sum of the following components:
- 1) Floor Component: Based on the supplemental payments needed to result in a provider's estimated payment loss of negative three percent, rounded to the nearest thousand dollars, using the following formula:
 - A)
$$\frac{[(\text{Reported legacy system SFY 2013 claims payments}) + (\text{SFY 2011 legacy system supplemental payments}) * 0.97]}{(\text{Simulated new system SFY 2013 claim payments})}$$
 - B) A provider with an estimated payment loss percentage less than three percent will have a Floor Component equal to \$0.00.
 - 2) Balance Component: Based on a percent of the provider's remaining estimated loss after including the Floor Component, rounded to nearest thousand dollars, using the following formula:
 - A)
$$[(\text{Simulated new system SFY 2013 claims payments}) + (\text{Floor Component}) - ((\text{Reported legacy system SFY 2013 claim payments}) + (\text{SFY 2011 legacy system supplemental payments}))] * (\text{Balance Adjustment Percentage}) * -1.$$

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- B) Balance Adjustment Percentage based on provider type as follows:
- i) Safety Net hospitals: 70 percent
 - ii) Critical Access hospitals: 70 percent
 - iii) Hospital with both Perinatal level III and Trauma level I status: 70 percent
 - iv) All other qualifying DRG PPS hospitals with an estimated payment loss: 55 percent.

In subsection 148.296(c)(1) of Section 148.296 changed the language to read as follows: "The Department shall make Transitional Supplemental Payments for the first four years of the new inpatient and outpatient payment systems effective during SFY 2015 through SFY 2018."

In subsection 148.296(c)(2) of Section 148.296 deleted "October 2015" and added "January 2017", deleted "July 1, 2016" and added "July 1, 2018".

In subsection 148.296(c)(3) of Section 148.296 deleted "July 1, 2016" and added " July 1, 2018".

Added New Section: "148.299" entitled "Medicaid Facilitation and Utilization Payments"
"Medicaid Facilitation and Utilization Payments shall be made on a monthly basis as follows:

- a) Qualifying Hospitals. Hospitals may qualify for the Medicaid Facilitation and Utilization Payments if they meet any of the following criteria:
 - 1) The hospital must be an Illinois general acute care hospital that had an increase over 35% of the total Medicaid days, excluding Medicare crossover days, from State Fiscal Year 2009 to State Fiscal Year 2013 as recorded in the Department's paid claims data, had more than 50 routine beds as included in the 2012 cost report

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filed with the Department, and for State Fiscal Year 2013, the average length of stay was less than 4.5 days.

- 2) The hospital must be an Illinois general acute care hospital that had a Medicaid Inpatient Utilization Rate (MIUR), as defined in 148.120(i)(4), between 50 and 80 percent, is designated a Perinatal Level II facility, and had less than 110 routine beds as included in the 2012 Cost Report on file with the Department, and for State Fiscal Year 2013, provided greater than 6,000 Medicaid days, excluding Medicare crossover days, as recorded in the Department's paid claims database.
 - 3) The hospital must be an Illinois children's hospital, as defined in 148.25(D)(3)(B), had greater than 10 routine beds as included in the 2012 cost report on file with the Department, and for State Fiscal Year 2013, the average length of stay was less than 4.5 days.
- b) Rates.
- 1) Hospitals qualifying under subsection (a)(1) of this Section will receive the following:
 - A) If the hospital provided more than 4,000 covered Medicaid days, excluding Medicare crossover days in State fiscal year 2013, as recorded in the Department's paid claims database, the rate is \$947.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.
 - B) If the hospital provided less than 4,000 covered Medicaid days, excluding Medicare crossover days in State fiscal year 2013, as recorded in the Department's paid claims database, the rate is \$76.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.
 - 2) Hospitals qualifying under subsection (a)(2) of Section will receive the following:

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- A) If the hospital had greater than 100 routine beds as included in the 2012 Cost Report on file with the Department, the rate is \$205.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.
- B) If the hospital had less than 100 routine beds as included in the 2012 Cost Report on file with the Department, the rate is \$59.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.
- 3) Hospitals qualifying under subsection (a)(3) of this Section will receive a rate of \$390.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.
- c) Payment for a qualifying hospital shall be the product of the rate as defined in subsection (b) of this Section, multiplied by their SFY 2013 covered days less Medicare crossover days as recorded in the Department's paid claims data (adjudicated through February 21, 2014)."

In subsections 148.442, 148.446, 148.448, 148.450, 148.456, 148.458, 148.464 and 148.482, deleted "This Section shall no longer be in effect as of January 1, 2015."

- 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 these rulemaking replace any emergency rule currently in effect? No
- 14) Are there any other rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform. These rules have also been modified based on negotiations for SB 741 of the 98th General Assembly which became law June 16, 2014 (Public Act 98-651).

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- 16) Information and questions regarding these adopted rules shall be directed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd 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 d: MEDICAL PROGRAMS

PART 148

HOSPITAL SERVICES

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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 (Repealed)
148.90	Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments (Repealed)
148.95	Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments (Repealed)
148.100	County Trauma Center Outpatient Rural Hospital Adjustment Payments
148.103	Outpatient Service Adjustment Payments (Repealed)
148.105	Reimbursement Methodologies for Inpatient Rehabilitation Services Psychiatric Adjustment Payments
148.110	Reimbursement Methodologies for Inpatient Psychiatric Services Base Rate Adjustment Payments
148.112	Medicaid High Volume Adjustment Payments
148.115	Reimbursement Methodologies for Long Term Acute Care Services Rural Adjustment Payments
<u>148.116</u>	<u>Reimbursement Methodologies for Children's Specialty Hospitals</u>
148.117	Outpatient Assistance Adjustment Payments
148.120	Disproportionate Share Hospital (DSH) Adjustments

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- 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
- 148.150 Public Law 103-66 Requirements
- 148.160 Payment Methodology for County-Owned Large Public Hospitals ~~in an Illinois County with a Population of Over Three Million~~
- 148.170 Payment Methodology for University-Owned Large Public Hospitals ~~Organized Under the University of Illinois Hospital Act~~
- 148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act (Repealed)
- 148.180 Payment for Pre-operative Days and; Patient Specific Orders, ~~and Services Which Can Be Performed in an Outpatient Setting~~
- 148.190 Copayments
- 148.200 Alternate Reimbursement Systems (Repealed)
- 148.210 Filing Cost Reports
- 148.220 Pre September 1, 1991, Admissions (Repealed)
- 148.230 Admissions Occurring on or after September 1, 1991 (Repealed)
- 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 (Repealed)
- 148.260 Calculation and Definitions of Inpatient Per Diem Rates (Repealed)
- 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 (Repealed)
- 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements (Repealed)
- 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 Transitional Supplemental Tertiary Care Adjustment Payments
- 148.297 Physician Development Incentive Payments ~~Pediatric Outpatient Adjustment Payments~~
- 148.298 Pediatric Inpatient Adjustment Payments (Repealed)
- 148.299 Medicaid Facilitation and Utilization Payments
- 148.300 Payment
- 148.310 Review Procedure

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- 148.320 Alternatives (Repealed)
- 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 Sub_acute Alcoholism and Substance Abuse Treatment Services
- 148.380 Rate Appeals for Sub_acute 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)
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- 148.420 Obstetrical Care Adjustment Payments (Repealed)
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- 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)
- 148.436 Long Term Stay Hospital Per Diem Payments
- 148.440 High Volume Adjustment Payments
- 148.442 Inpatient Services Adjustment Payments
- 148.444 Capital Needs Payments
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- 148.448 Trauma Care Payments
- 148.450 Supplemental Tertiary Care Payments
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- 148.454 Magnet Hospital Payments

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148.456	Ambulatory Procedure Listing Increase Payments
148.458	General Provisions
148.460	Catastrophic Relief Payments <u>(Repealed)</u>
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148.464	General Provisions
148.466	Magnet and Perinatal Hospital Adjustment Payments
148.468	Trauma Level II Hospital Adjustment Payments
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148.500	Definitions
148.510	Reimbursement

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
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SUBPART E: INSTITUTION FOR MENTAL DISEASES PROVISIONS FOR HOSPITALS

Section	
148.700	General Provisions

SUBPART F: EMERGENCY PSYCHIATRIC DEMONSTRATION PROGRAM

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Section

148.800	General Provisions
148.810	Definitions
148.820	Individual Eligibility for the Program
148.830	Providers Participating in the Program
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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 and 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. 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

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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 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,

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effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002; amended at 26 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 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;

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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. 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; expedited correction at 38 Ill. Reg. 12618, 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

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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; amended at 37 Ill. Reg. 17631, effective October 23, 2013; amended at 38 Ill. Reg. 4363, effective January 29, 2014; amended at 38 Ill. Reg. 11557, effective May 13, 2014; amended at 38 Ill. Reg. 13263, effective June 11, 2014; amended at 38 Ill. Reg. 15165, effective July 2, 2014.

SUBPART A: GENERAL PROVISIONS

Section 148.20 ParticipationEffective for dates of service on or after July 1, 2014:

- a) Payment for hospital inpatient, outpatient and clinic services shall be made only when provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), for covered services, as described in Section 148.50.
- b) ~~Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992 through March 31, 1994 shall be as follows:~~
 - 1) ~~Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the base inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under the following Sections: 148.130, 148.260, 148.270, and 148.280.~~
 - 2) ~~Exemptions. The provisions of subsection (b)(1) shall not apply to:~~

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- A) ~~Hospitals reimbursed under Sections 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with Sections 148.82, 148.160, or 148.170, as applicable.~~
- B) ~~Hospitals reclassified as rural hospitals as described in Section 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with Section 148.40(f)(4) and Section 148.260 or 89 Ill. Adm. Code 149.100(e)(1)(A), whichever is applicable.~~
- C) ~~The inpatient payment adjustments described in Sections 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with Sections 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1).~~

b)e) Payment for freestanding emergency center services shall only be made when provided by a freestanding emergency center as defined in Section 148.25(e)~~148.25(h)~~ of this Part.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.25 Definitions and Applicability

Effective for dates of service on or after July 1, 2014:

- a) The term "large public hospital" means a hospital:
 - 1) Owned by and located in an Illinois county with a population exceeding three million; or
 - 2) Organized under the University of Illinois Hospital Act; or
 - 3) Maintained by the Illinois Department of Human Services. Payment for hospital inpatient, hospital outpatient and hospital clinic services shall be made only to a hospital or a distinct part hospital unit as defined in this Section.
- b) The term "hospital" means:

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- 1) For the purpose of hospital inpatient reimbursement, any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, ~~that~~which
 - A) Is subject to licensure by the Illinois Department of Public Health (DPH) under the Hospital Licensing Act.
 - B) Is organized under the University of Illinois Hospital Act.
 - C) Is maintained by the State, or any department or agency of the State, when the department or agency has authority under the law to establish and enforce standards for the hospitalization or care facilities under its management and control.
 - D) Meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.~~is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building or agency, public or private, whether organized for profit or not for profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located. In addition, unless specifically indicated otherwise, for the purpose of inpatient reimbursement, the term "hospital" shall also include:~~
 - A) ~~County-owned hospitals, meaning all county-owned hospitals that are located in an Illinois county with a population of over 3 million.~~
 - B) ~~A hospital organized under the University of Illinois Hospital Act.~~
 - C) ~~A hospital unit that is adjacent to or on the premises of the hospital and licensed under the Hospital Licensing Act or the University of Illinois Hospital Act.~~
- 2) For the purpose of hospital outpatient reimbursement, the term "hospital" shall, in addition to the definition described in subsection (b)(1) ~~of this~~

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~~Section, include an encounter rate hospital. An encounter rate hospital is defined as:~~

- A) ~~An ambulatory surgical treatment facility, as described in 89 Ill. Adm. Code 146.105(a). An Illinois county-owned hospital located in a county with a population exceeding three million;~~
 - B) ~~A free-standing emergency center, as described in subsection (e) of this Section. hospital organized under the University of Illinois Hospital Act; or~~
 - C) ~~A county-operated outpatient facility located in a county with a population exceeding three million that is also located in the State of Illinois.~~
- 3) For the purpose of non hospital-based clinic reimbursement, the term "hospital" shall mean a county-operated outpatient facility owned by and located in an Illinois county with a population exceeding three million.
- A) ~~A county-operated outpatient facility, as described in subsection (b)(2)(D) of this Section; or~~
 - B) ~~A Certified Hospital Organized Satellite Clinic, as described in 89 Ill. Adm. Code 140.461(f)(1)(B).~~
- 4) For the purpose of hospital-based clinic reimbursement, the term "hospital" shall mean a hospital-based clinic meeting the provisions of Section 148.40(d) and 89 Ill. Adm. Code 140.461(a) ~~and Section 148.40(d).~~
- 5) ~~For the purpose of Maternal and Child Health reimbursement, as described in 89 Ill. Adm. Code 140.464 and Section 148.140(d)(6), the term "Maternal and Child Health Managed Care Clinic" shall mean a clinic meeting the requirements of 89 Ill. Adm. Code 140.461(f). The following four categories of Maternal and Child Health Managed Care Clinics are recognized under the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140, Subpart G:~~

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- A) ~~Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A);~~
- B) ~~Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B);~~
- C) ~~Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C); and~~
- D) ~~Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D).~~
- 6) ~~For the purpose of disproportionate share hospital adjustments, the term "hospital" shall, in addition to the definition in subsection (b)(1) of this Section, mean the facilities operated by the Department of Human Services, including facilities that are accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO).~~
- c) For the purpose of hospital inpatient reimbursement, the term "distinct part ~~hospital~~-unit" means a unit within a hospital, as defined in subsection (b)(1) ~~of this Section~~, that meets the following qualifications:
- 1) ~~Distinct Part Psychiatric Units. A distinct part psychiatric unit is a hospital, with a functional psychiatric~~ unit, that is enrolled with the Department to provide inpatient psychiatric services (category of service 021).
- 2) ~~Distinct Part Rehabilitation Units. A distinct part rehabilitation unit is a hospital, with a functional rehabilitation~~ unit, that is enrolled with the Department to provide inpatient rehabilitation services (category of service 022).
- d) Specialty Hospitals ~~A major teaching hospital is defined as a hospital having four or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation. Except, in the case of a hospital devoted exclusively to physical rehabilitation, as defined in 89 Ill. Adm.~~

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~~Code 149.50(c)(2), or in the case of a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), only one certified program is required to be so classified.~~

- 1) Psychiatric Hospitals. To qualify as a psychiatric hospital, a facility must be:
 - A) Licensed by the state within which it is located as a psychiatric hospital and be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons.
 - B) Enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 021).
- 2) Rehabilitation Hospitals. To qualify as a rehabilitation hospital, a facility must be:
 - A) Licensed by the state within which it is located as a physical rehabilitation hospital.
 - B) Enrolled with the Department as a rehabilitation hospital to provide inpatient physical rehabilitation services (category of service 022).
- 3) Children's Hospitals. To qualify as a children's hospital, a facility must be devoted exclusively to caring for children and either be:
 - A) A hospital licensed by the state within which it is located as a pediatric, psychiatric or children's hospital.
 - B) A unit within a general hospital that was enrolled with the Department as a children's hospital on July 1, 2013. Units so enrolled shall be reimbursed for all inpatient and outpatient services provided to Medical Assistance enrollees who are under 18 years of age, with the exception of obstetric services, normal newborn nursery services, psychiatric services, and physical

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rehabilitation services, without regard to the physical location within the hospital where the care is rendered.

- 4) Long Term Acute Care Hospitals. To qualify as a long term acute care hospital, a facility must be licensed by the state within which it is located as an acute care hospital and certified by Medicare as a long term care hospital.
- e) The term "freestanding emergency center" means a facility that provides comprehensive emergency treatment services 24-hours per day, on an outpatient basis, and has been issued a license by the Illinois Department of Public Health under the Freestanding Emergency Center Code (77 Ill. Adm. Code 518), as a freestanding emergency center, or a facility outside of Illinois that meets conditions and requirements comparable to those found in the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] in effect for the jurisdiction in which it is located. Except as provided in subsection (d) of this Section, a teaching hospital is defined as a hospital having at least one, but no more than three, graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.
- f) The term "coordinated care participating hospital" means a hospital, located in a county 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 Section 5-30 of the Illinois Public Aid Code (Code) that: A non-teaching hospital is defined as:
 - 1) Has entered into a contract to provide hospital services to enrollees of the care coordination program. A hospital that reports teaching costs on the Medicare or Medicaid cost reports but has no graduate medical education programs; or
 - 2) 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-service basis, but excluding disproportionate share hospital adjustment payments or any other supplemental payment that the Department pays directly. A hospital that reports no teaching costs on the Medicare or Medicaid cost reports

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~~and that has no graduate medical education programs.~~

- g) ~~The term "critical access hospital" means a hospital, located in Illinois, that has been designated as a critical care hospital by DPH in accordance with 42 CFR 485, Subpart F, Definitions. Unless specifically stated otherwise, the definitions of terms used in Sections 148.130, 148.260, 148.270, and 148.280, and in 89 Ill. Adm. Code 149 are as follows:~~
- 1) ~~"Base period" means the two most recent cost report years for which audited cost reports are available for at least 90 percent of cost reporting hospitals.~~
 - 2) ~~"Rate period" means:~~
 - A) ~~For admissions, or if applicable, dates of service, on or after October 1, 1992, and on or before March 31, 1994, the 18 month period beginning on October 1, 1992, and ending on March 31, 1994.~~
 - B) ~~Beginning with admissions, or if applicable, dates of service, on or after April 1, 1994, the period beginning 90 days after the effective date of DRG PPS rates under the federal Medicare Program and ending 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.~~
 - 3) ~~"Rural hospital" means a hospital that is:~~
 - A) ~~Located:~~
 - i) ~~Outside a metropolitan statistical area; or~~
 - ii) ~~Located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health.~~

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- ~~B) The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993).~~
- ~~4) "Urban hospital" means a hospital that is located in a metropolitan statistical area that does not meet the criteria described in subsection (g)(3) of this Section.~~
- h) Academic Medical Centers and Major Teaching Hospital Status. Hospitals dedicated to medical research and medical education shall be classified each State fiscal year in 3 tiers based on specific criteria:
- 1) Tier I. A private academic medical center must:
- A) be a hospital located in Illinois that is:
- i) under common ownership with the college of medicine of a non-public college or university; or
- ii) a freestanding hospital in which the majority of the clinical chiefs of service or clinical department chairs are department chairs in an affiliated non-public Illinois medical school; or
- iii) a children's hospital that is separately incorporated and non-integrated into the academic medical center hospital but is the pediatric partner for an academic medical center hospital and that serves as the primary teaching hospital for pediatrics for its affiliated Illinois medical school. A hospital identified in this subsection (h)(i)(A)(iii) is deemed to meet the additional Tier I criteria if its partner academic medical center hospital meets the Tier I criteria;
- B) serve as the training site for at least 30 graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education;

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- C) facilitate the training on the campus or on affiliated off-campus sites of no less than 500 medical students, interns, residents and fellows during the calendar year preceding the beginning of the State fiscal year;
 - D) perform, either itself or through its affiliated university, at least \$12,000,000 in medical research funded through grants or contracts from the National Institutes of Health or, with respect to hospitals described in subsection (h)(1)(A)(ii), have as its affiliated non-public Illinois medical school a medical school that performs, either itself or through its affiliated university, medical research funded using at least \$12,000,000 in grants or contracts from the National Institutes of Health; and
 - E) expend, directly or indirectly, through an affiliated non-public medical school or as part of a hospital system, defined as a hospital and one or more other hospitals or hospital affiliates related by common control or ownership, no less than \$5,000,000 toward medical research and education during the calendar year preceding the beginning of the State fiscal year.
- 2) Tier II. A public academic medical center must:
- A) be a hospital located in Illinois that is a primary teaching hospital affiliated with:
 - i) University of Illinois School of Medicine at Chicago;
 - ii) University of Illinois School of Medicine at Peoria;
 - iii) University of Illinois School of Medicine at Rockford;
 - iv) University of Illinois School of Medicine at Urbana; or
 - v) Southern Illinois University School of Medicine in Springfield; and

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- B) contribute no less than \$2,500,000 toward medical research and education during the calendar year preceding the beginning of the State fiscal year.
- 3) Tier III. A major teaching hospital must:
- A) be an Illinois hospital with 100 or more interns and residents or with a ratio of interns and residents to beds greater than or equal to 0.25; and
- B) support at least one graduate medical education program accredited by the Accreditation Council for Graduate Medical Education. The term "freestanding emergency center" means a facility that provides comprehensive emergency treatment services 24 hours per day, on an outpatient basis, and has been issued a license by the Illinois Department of Public Health under the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] as a freestanding emergency center, or a facility outside of Illinois that meets conditions and requirements comparable to those found in the EMS Systems Act in effect for the jurisdiction in which it is located.
- i) Children's Specialty Hospital. To qualify as a children's specialty hospital, a facility must be:
- 1) an Illinois hospital as defined in subsection (d)(3)(A) and have fewer than 50 total inpatient beds; or
- 2) a cost reporting hospital, as defined in subsection (d)(3)(A), located outside of Illinois and have fewer than 50 total beds and an average length of stay greater than 20 days in State fiscal year 2013, as contained in the Department's claims data warehouse.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.30 General Requirements

Effective for dates of service on or after July 1, 2014:

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- a) For the purpose of hospital inpatient, hospital outpatient and hospital-based clinic reimbursement, the following requirements must be met by a hospital to qualify for enrollment in the Illinois Medical Assistance Program:
- ~~b)1) The hospital must be certified for participation in the Medicare Program (Title XVIII) unless the provisions of subsection (c)(a)(2) of this Section apply.~~
- ~~c)2) If not eligible for or subject to Medicare certification, the hospital must be accredited by The Joint Commission (TJC)~~on the Accreditation of Healthcare Organizations (JCAHO).~~~~
- ~~d)3) The hospital must agree to accept the Department's basis for reimbursement.~~
- ~~b) Hospitals shall be required to file Medicaid and Medicare cost reports with the Office of Health Finance, Illinois Department of Public Aid, in accordance with Section 148.210, and shall have reimbursable hospital inpatient, outpatient and hospital-based clinic rates approved by the Department.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.40 Special Requirements

Effective for dates of discharge on or after July 1, 2014:

- a) Inpatient Psychiatric Services
- 1) Payment for inpatient hospital psychiatric services shall be made only to:
- A) A hospital that is a general hospital, as defined in Section 148.25(b), with a functional unit, as defined in Section 148.25(c)(1), that specializes in, and is enrolled with the Department to provide, psychiatric services; or
- B) A hospital, as defined in Section 148.25(b), that holds a valid license as, and is enrolled with the Department as, a psychiatric hospital, as defined in Section 148.25(d)(1).~~89 Ill. Adm. Code 149.50(c)(1).~~

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- 2) Inpatient psychiatric services are those services provided to patients who are in need of short-term acute inpatient hospitalization for active treatment of an emotional or mental disorder.
- ~~3) Inpatient psychiatric services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.~~
- ~~3)4)~~ Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 and under the age of 65. In the case of a patient receiving psychiatric services immediately preceding his or /her 21st birthday, ~~reimbursement for~~ psychiatric services shall be reimbursable by the Department~~shall be provided~~ until the earliest of the following:
- A) The date the patient no longer requires the services, ~~or~~
- B) The date the patient reaches 22 years of age.
- ~~4)5)~~ A psychiatric hospital must be accredited by ~~TJC~~the Joint Commission on the Accreditation of Health Care Organizations to provide services to program participants under 21 years of age or be Medicare certified to provide services to program participants 65 years of age and older. Distinct part psychiatric units and psychiatric hospitals located in ~~the State of~~ Illinois, or within ~~a 100 mile~~mile radius of the State of Illinois, must execute an ~~interagency~~ agreement with an Illinois Department of Human Services (DHS) operated mental health center (State-operated facility) for coordination of services including, but not limited to, crisis screening and discharge planning to ensure linkage to aftercare services with private practitioners or community mental health services, as described in subsection (a)~~(5)(6)~~ of this Section.
- ~~5)6)~~ Coordination of Care – Purpose. ~~In accordance with subsection (a)(5) of this Section, distinct part psychiatric units and psychiatric hospitals located in the State of Illinois, or within a 100 mile radius of the State of~~

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~~Illinois, must execute a Coordination of Care Agreement in order to participate as a provider of inpatient psychiatric services.~~ The Coordination of Care Agreement shall set forth an agreement between the ~~DHS operated mental health center (State-operated facility)~~ and the hospital for the coordination of services, including but not limited to crisis screening and discharge planning to ensure efficient use of inpatient care. The agreement shall also set forth the manner in which linkage to aftercare services with community mental health agencies or private practitioners shall be carried out.

~~6)7)~~ Coordination of Care – General Provisions. The general provisions of the Coordination of Care Agreement described in subsection (a) ~~(5)(6) of this Section~~ are as follows:

- A) The hospital shall agree, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations and shall maintain accreditation by ~~TJC, JCAHO;~~
- B) The provider shall comply with Title VI of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973 and regulations promulgated ~~under those Acts thereunder which~~ prohibit discrimination on the grounds of sex, race, color, national origin or handicap.;
- C) The provider shall comply with the following applicable federal, State and local statutes pertaining to equal employment opportunity, affirmative action, and other related requirements: 42 USCA 2000e, 29 USCA 203 et seq. and 775 ILCS 25.;
- D) The Coordination of Care Agreement shall remain in effect until amended by mutual consent or cancelled in writing by either party having given 30 days prior notification.

~~7)8)~~ Coordination of Care – Special Requirements. The hospital shall:

- A) Provide on its premises, the facilities, staff, and programs for the diagnosis, admission, and treatment of persons who may require inpatient care ~~and/or~~ assessment of mental status, mental illness,

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emotional disability, and other psychiatric problems.~~;~~

- B) Notify the community mental health agency that serves the geographic area from which the recipient originated to allow the agency to prescreen the case prior to referring the individual to the designated State-operated facility. The community mental health agency's resources and other appropriate community alternatives shall be considered prior to making a referral to the State-operated facility for admission.~~;~~
- C) Complete any forms necessary and consistent with the Mental Health and Developmental Disabilities Code in the event of a referral for involuntary or judicial admission.~~;~~
- D) Notify the community mental health agency or private practitioner of the date and time of discharge and invite their participation in the discharge planning process.~~;~~
- E) Refer to the State-operated facility only those individuals for whom less restrictive alternatives are documented not to be appropriate at the time based on a clinical determination by the community mental health agency, a private practitioner (if applicable), or the hospital.~~;~~ ~~and~~
- F) Notify the State-operated facility prior to planned transfer of an individual and transfer the individual at such time as to assure arrival of the person prior to 11 a.m. Monday through Friday. In unusual situations, transfers may be made at other times after prior discussion between the hospital and the State-operated facility. The individual will only be transported to the State-operated facility when, based on a clinical determination, he ~~or~~ /she is medically stable as determined by the transferring physician. A copy of the transfer summary from the hospital must accompany the recipient at the time of admission to the State-operated facility.

~~8)9)~~ Coordination of Care – Special Requirements of the State-Operated Facility. The State-operated facility shall:

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- A) Admit individuals who have been screened as defined in the Coordination of Care Agreement and are appropriate for admission consistent with the provisions of the Mental Health and Developmental Disabilities Code.
- B) Evaluate individuals for whom the hospital has executed a Petition and Certificate for involuntary/judicial admission consistent with the Mental Health and Developmental Disabilities Code.
- C) Consider for admission voluntary individuals for whom less restrictive alternatives are documented not to be appropriate at the time, based on a clinical determination by the community mental health agency, private practitioner (if applicable), the hospital, or the State-operated facility.

~~9)10)~~ Coordination of Care – Special Requirements for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program. For ~~individuals~~patients under 21 years of age, all inpatient admissions must be authorized through the SASS Program. The hospital shall:

- A) Prior to admission, contact the Crisis and Referral Entry Service (CARES), the Department's Statewide centralized intake and referral point for a mental health screening and assessment of the patient, pursuant to 59 Ill. Adm. Code 131.40;
- B) For admissions authorized through a SASS screening, involve the SASS provider in the patient's treatment plan during the inpatient stay and in the development of a discharge plan in order to facilitate linkage to appropriate aftercare resources.

~~10)11)~~ A participating hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service only on an emergency basis for a maximum period of 72 hours or in cases in which the psychiatric services are secondary to the services for which the period of hospitalization is approved.

b) Inpatient Rehabilitation Services

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- 1) Payment for inpatient rehabilitation services shall be made only to a general hospital, as defined in Section 148.25(b), with a functional unit of the hospital, as defined in Section 148.25(c)(2), which specializes in, and is enrolled with the Department to provide, physical rehabilitation services or a hospital, as defined in ~~Section 148.25(d)(2)~~^{89 Ill. Adm. Code 149.50(e)(2)}, which holds a valid license as, and is enrolled with the Department as, a physical rehabilitation hospital.
- 2) The primary reason for hospitalization is to provide a structured program of comprehensive rehabilitation services, furnished by specialists, to the patient with a major handicap for the purpose of habilitating or restoring the person to a realistic maximum level of functioning.
- ~~3) Inpatient rehabilitation services are not covered for Temporary Assistance for Needy Families (TANF) program participants who are 18 years of age or older.~~
- ~~3)4) For payment to be made, a rehabilitation facility, which includes a distinct part unit as described in Section 148.25(c)(2), must be certified by the Health Care Financing Administration for participation under the Medicare Program (Title XVIII) and must be licensed and/or certified by the Department of Public Health (DPH) to provide comprehensive physical rehabilitation services. Out-of-state hospitals that specialize in physical rehabilitation services must be licensed or certified to provide comprehensive physical rehabilitation services by the authorized licensing agency in the state in which the hospital is located.~~
- ~~4)5) A rehabilitation facility must meet the following criteria:~~
 - A) Have a full-time (at least 35 hours per week) director of rehabilitation; a participating general hospital with a functional rehabilitation unit must have a part-time (at least 20 hours per week) director of rehabilitation.;
 - B) Have an organized medical staff.;
 - C) Have available consultants qualified to perform services in appropriate specialties.;

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- D) Have adequate space and equipment to provide comprehensive diagnostic and treatment services.;
- E) Maintain records of diagnosis, treatment progress (notations must be made at regular intervals) and functional results.;
- F) Submit reports as required by the Department of Healthcare and Family Services (HFS).

~~5)6)~~ A rehabilitation facility must provide, or have a contractual arrangement with an appropriate entity or agency to provide, the following minimal services:

- A) Full-time nursing services under the supervision of a registered nurse formally trained in rehabilitation nursing.;
- B) Full-time physical therapy and occupational therapy services.;
- C) Social casework services as an integral part of the rehabilitation program.

~~6)7)~~ A rehabilitation facility must have available the following minimal services:

- A) Psychological evaluation services.;
- B) Prosthetic and orthotic services.;
- C) Vocational counseling.;
- D) Speech therapy.;
- E) Clinical laboratory and x-ray services.;
- F) Pharmacy services.

~~7)8)~~ The director of rehabilitation must meet the following criteria:

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- A) Provide services to the hospital and its patients as specified in subsection (b)~~(4),(5) of this Section~~;
- B) Be a doctor of medicine or osteopathy~~;~~;
- C) Be licensed under State law to practice medicine or surgery~~;~~ ~~and~~
- D) Must have, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

~~8)9)~~ Personnel of the rehabilitation facility must meet the following minimum standards:

- A) Physicians shall have unlimited licenses to practice medicine and surgery in the state in which they practice. Consultants shall be Board Qualified or Board Certified in their specialty.
- B) Physical therapists shall be licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state in which the facility is located.
- C) Occupational therapists shall be licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state in which the facility is located.
- D) Registered nurses and licensed practical nurses shall be currently licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the ~~state~~State in which the facility is located.
- E) Social workers shall have completed two years of graduate training leading to a Master's Degree in social work from an accredited graduate school of social work.
- F) Psychologists shall have a Master's Degree in clinical psychology.

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- G) Vocational counselors shall have a Master's Degree in Rehabilitation Counseling, Psychology or Guidance from a school accredited by the North Central Association or its equivalent.
 - H) An orthotist or prosthetist, certified by the American Board of Certification in Orthotics and Prosthetics, shall fabricate or supervise the fabrication of all limbs and braces.
- c) End-Stage Renal Disease Treatment (ESRDT) Services. The Department provides payment to hospitals, as defined in Section 148.25(b), for ESRDT services only when the hospital is Medicare certified for ESRDT and services are provided as follows:
- 1) Inpatient hospital care is provided for the evaluation and treatment of acute renal disease.~~;~~
 - 2) Outpatient chronic renal dialysis treatments are provided in the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, or a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (~~20131994~~);~~or~~
 - 3) Home dialysis treatments are provided through the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, in a patient's home, or through a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (~~20131994~~).
- d) Hospital-Based Organized Clinic Services. Hospital-based clinics, as described in Section 148.25(b)(4), must meet the requirements of 89 Ill. Adm. Code 140.461(a). The following two categories of hospital-based organized clinic services are recognized in the Medical Assistance Program:
- 1) Psychiatric Clinic Services
 - A) Psychiatric Clinic Services (Type A). Type A psychiatric clinic

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services are clinic service packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling, provided in the hospital clinic setting.

- B) Psychiatric Clinic Services (Type B). Type B psychiatric clinic services are active treatment programs in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four hours per day at a minimum of three half days of active treatment per week. The duration of an individual patient's participation in this treatment program is limited to six months in any 12 month period.

~~C) Coverage. Psychiatric clinic services are covered for all Medicaid-eligible individuals. The services are not covered for TANF participants who are 18 years of age or older.~~

~~C)D) Approval. The Department and DHS~~Department of Human Services and HFS are responsible for approval and enrollment of community hospitals providing psychiatric clinic services. In order to participate as a provider of psychiatric clinic services, a hospital must have previously been enrolled with the Department for the provision of inpatient psychiatric services on or after June 1, 2002 or must be currently enrolled for the provision of inpatient psychiatric services and execute a Psychiatric Clinic Services Type A and B Enrollment Assurance with DHS and ~~the Department~~HFS, which assures that the hospital is enrolled for the provision of inpatient psychiatric services and meets the following requisites:

- i) The hospital must be accredited by, and be in good standing with, ~~TJC, the Joint Commission on Accreditation of Health Care Organizations (JCAHO);~~
- ii) The hospital must have executed a Coordination of Care Agreement between the hospital and the designated DHS State-operated facility serving the mentally ill in the appropriate geographic area.;

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- iii) The clinical staff of the psychiatric clinic must collaborate with the mental health service network to provide discharge, linkage and aftercare planning for recipients of outpatient services.
 - ~~iv) The hospital must agree to participate in Local Area Networks in compliance with P.L. 99-660 and P.A. 86-844; and~~
 - ~~iv)v) The hospital must be enrolled to participate in Medicaid Program (Title XIX) and must meet all conditions and requirements set forth by the Department HFS.~~
 - ~~D)E) Duration of Approval. The approval described in subsection (d)(1)(D) of this Section shall be in effect for a period of two years from the date HFS approves the psychiatric clinic's enrollment. The approval may be terminated by HFS or DHS with cause upon 30 days written notice to the hospital. Accordingly, the hospital must submit a 30 day written notification to HFS and DHS when terminating delivery of psychiatric clinic services.~~
- 2) Physical Rehabilitation Clinic Services
- ~~A) Physical rehabilitation clinic services include the same rehabilitative services provided to inpatients by hospitals enrolled to provide the services described in Section 148.40(b). Clinic services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an outpatient basis through the hospital's specialized clinic.~~
 - ~~B) Physical rehabilitation clinic services are not covered for TANF participants who are 18 years of age or older.~~
- ~~e) Maternal and Child Health Clinics. Maternal and Child Health Clinics, as described in 89 Ill. Adm. Code 140.461(f) and Section 148.25(b)(5), must meet the requirements of 89 Ill. Adm. Code 140.461(f).~~
 - ~~f) Transition to the Diagnosis Related Grouping Prospective Payment System (DRG PPS) (see 89 Ill. Adm. Code 149)~~

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- 1) ~~Effective with admissions occurring on or after September 1, 1991, and before October 1, 1992, hospitals shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered.~~
- 2) ~~Effective with admissions occurring on or after October 1, 1992, hospitals that, on August 31, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act [20 ILCS 2215] and that elected, effective September 1, 1991, to be reimbursed at rates stated in such contracts, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care in accordance with subsection (g) of this Section.~~
- 3) ~~In the case of a hospital that was determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient services during the rate period described in Section 148.25(g)(2)(A):~~
 - A) ~~the DRG PPS, as described in 89 Ill. Adm. Code 149, or~~
 - B) ~~the rate calculated under Section 148.260.~~
- 4) ~~In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in Section 148.25(g)(3), on July 14, 1993, those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A):~~
 - A) ~~the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to~~

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- ~~the provisions of 89 Ill. Adm. Code 149.100(c)(1), or~~
- B) ~~the rate calculated under Section 148.260 that would have been in effect for the rate period described in Section 148.25(g)(2)(A) if the hospital had been designated as a sole community hospital on October 1, 1992.~~
- 5) ~~For the rate periods described in Section 148.25(g)(2)(B), hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided during such rate periods described in Section 148.25(g)(2)(B):~~
- A) ~~the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(c)(1), or~~
- B) ~~the rate calculated under Section 148.260.~~
- g) ~~Annual Irrevocable Election~~
- 1) ~~Hospitals described in subsections (f)(2) and (f)(3) of this Section may elect to be reimbursed under the special arrangements described in subsections (f)(2) and (f)(3) at the beginning of each rate period.~~
- 2) ~~Hospitals described in subsection (f)(4) of this Section may elect to be reimbursed under the special arrangements described in subsection (f)(4) effective with admissions, or, if applicable, with inpatient services provided, on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A).~~
- 3) ~~Hospitals described in subsection (f)(5) of this Section may elect to be reimbursed under the special arrangements described in subsection (f)(5) at the beginning of each rate period described in Section 148.25(g)(2)(B).~~
- 4) ~~Once a sole community hospital elects to be reimbursed under the DRG PPS, it may not later in that rate period elect to be classified as exempt. Once a sole community hospital elects to be reimbursed as exempt, it may not later in that rate period elect to be reimbursed under the DRG PPS.~~

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- 5) ~~Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care. Once such election has been made, the hospital may not later in that rate period elect to be reimbursed under any other methodology.~~
- 6) ~~Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act and have elected to be reimbursed under the DRG PPS may not later elect to be reimbursed at rates stated in such contracts.~~
- h) Notification of Reimbursement Methodology
- 1) ~~Hospitals shall receive notification from the Department with respect to the reimbursement methodologies that shall be in effect for admissions occurring during the rate period.~~
- 2) ~~Hospitals described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) of this Section shall receive notification of their reimbursement options accompanied by a Choice of Reimbursement form. Each hospital described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) shall have 30 days after the date of such notification to file, with the Department, the reimbursement method of choice for the rate period. In the event the Department has not received the hospital's Choice of Reimbursement form within 30 days after the date of notification, as described in this Section, the hospital will automatically be reimbursed for the rate period under the reimbursement methodology that would have been in effect without benefit of the election described in subsection (g) of this Section.~~
- e)i) Zero Balance Bills. The Department requires a hospital to submit a bill for any inpatient service provided to an individual enrolled in any of the Medical Assistance Programs administered by the Department~~Illinois Medicaid eligible person~~, including newborns, regardless of payer/payor. A "zero balance bill" is one on which the total "prior payments" are equal to or exceed the Department's liability on the claim. The Department requires that zero balance bills be submitted subsequent to discharge in the same manner as are other bills so that information may~~can~~ be available for the maintenance of accurate patient profiles

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and diagnosis-related grouping (DRG) data, and information needed for calculation of disproportionate share and other rates. The provisions of this subsection apply to all hospitals regardless of the reimbursement methodology under which they are reimbursed.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.50 Covered Hospital Services

Effective for dates of outpatient services on or after July 1, 2014 and inpatient discharges on or after July 1, 2014:

- a) The Department shall pay hospitals for the essential provision of inpatient, outpatient, and clinic diagnostic and treatment services not otherwise excluded or limited ~~that which~~ are provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), and ~~that which~~ are provided in compliance with hospital licensing standards. Payment may be made for the following types of care subject to the special requirements described in Section 148.40:
 - 1) General/specialty services.;
 - 2) Psychiatric services.;
 - 3) Rehabilitation services.;
 - 4) End-Stage Renal Disease Treatment (ESRDT) services.
- b) Certain ~~services programs~~ are ~~defined administered~~ as hospital covered services with certain restrictions. These programs include hospital residing long term care services, subacute alcoholism and substance abuse treatment services, and the transplant program.
- c) Hospital Residing Long Term Care Services
 - 1) Long term care services are not considered by the Department to be hospital services unless the hospital is enrolled with the Department specifically to provide hospital residing long term care services as a

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hospital-based long term care facility. Hospital residing long term care is care provided by hospitals to non-acute patients requiring chronic, skilled nursing care when a skilled nursing facility bed is not available, or non-acute care provided by hospitals that is not routinely performed within a skilled setting, such as ventilator care, when appropriate placements are not available to discharge the patient. Hospitals may not utilize the following beds or facilities for hospital services unless the hospital is enrolled with the Department to provide hospital residing long term care:

- A) A special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program; or
 - B) A special unit or separate facility administratively associated with the hospital and licensed as a long term care facility.
- 2) There are three categories of service for hospital residing long term care. These categories are as follows:
- A) Skilled Care – Hospital Residing (category of service 037)
Reimbursement is available for hospitals providing hospital residing long term care when the patients' needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed. Reimbursement for this type of care is at the average statewide rate for skilled nursing care. For a hospital to be eligible for such reimbursement, the following criteria must be met:
 - i) The hospital must document its attempt to place the patient in at least five appropriate facilities.
 - ii) Documentation (form HFS 3127DPA-3127) must be attached to the appropriate claim form and submitted to the Department.
 - iii) Reimbursement is limited to services provided after the minimum number of contacts hashave been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being

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medically necessary. Reimbursement ~~may will~~ be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

- B) Exceptional Care – Hospital Residing (category of service 038) Reimbursement is available for hospitals providing hospital residing long term care when the level of care is not routinely performed within a skilled setting, such as ventilator care, and the patient cannot be placed in a skilled nursing facility because the level of care is not available. Exceptional care is defined by the Department as the level of care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physician, nurse, and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be a medical necessity. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or a related condition, head injured persons, and ventilator dependent persons. Reimbursement for this type of care is at the average statewide rate for exceptional care. For a hospital to be eligible for ~~thesueh~~ reimbursement, the following criteria must be met:

- i) The ~~hospital~~hospital must document its attempt to place the patient in at least five appropriate facilities.
- ii) Documentation (form ~~HFS 3127~~DPA 3127) must be attached to the appropriate claim form and submitted to the Department.
- iii) Reimbursement is limited to services provided after the minimum number of contacts ~~has~~have been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement ~~may will~~ be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

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- C) ~~IDDD~~/MI Non-Acute Care – Hospital Residing (category of service 039)
Reimbursement is available for hospitals providing hospital residing long term care when the pre-admission screening agent has not completed the assessment, planning or discharge process. Reimbursement for this type of care is at the average statewide ~~DD/MI~~ rate for intermediate care facilities for persons with intellectual disabilities. For a hospital to be eligible for such reimbursement, the following criteria must be met:
- i) The hospital must document that the pre-admission screening agent has not completed the assessment, planning or discharge process.
 - ii) Reimbursement is limited to a maximum of three non-acute level of care days. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary.
- d) Subacute Alcoholism and Substance Abuse Treatment Services
~~1)Subacute alcoholism and other substance abuse treatment is a covered service for clients under Title XIX (Medicaid) and for children 13 to or through 18 years of age in Family and Children Assistance cases in the City of Chicago. 2)Only acute alcoholism and substance abuse treatment services (detoxification) are covered as hospital services. RulesRegulations~~ regarding reimbursement for subacute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.
- e) Transplant Program
The Medical Assistance Program provides for payment for organ transplants only when provided by a certified transplantation center as described in Section 148.82. Payment for kidney and cornea transplants does not require enrollment as an approved transplantation center. ~~Payment for kidney and cornea transplants is made in accordance with the appropriate methodology described in Sections 148.160, 148.170, 148.250 through 148.300, or 89 Ill. Adm. Code 149.100 and 149.150. Kidney acquisition costs shall be reimbursed in accordance with 89 Ill. Adm. Code 149.150(c)(5). Payment for bone marrow, heart, liver, pancreas,~~

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~~kidney/pancreas and other types of transplant procedures may be covered and reimbursed in accordance with Section 148.82 provided the hospital is certified by the Department to perform the transplant.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.60 Services Not Covered as Hospital Services

Effective for dates of service on or after July 1, 2014, certain~~Certain~~ services, although included in the Medical Assistance Program and under certain circumstances provided in the hospital setting or by an entity associated with the hospital, are not reimbursed by the Department as hospital services. In addition, certain services currently provided in the hospital outpatient and hospital-based clinic setting are subject to fee-for-service payment methodologies. This means that for these services, hospitals shall be required to conform to the policies and billing procedures in effect for other non-hospital providers of services. Payment for these services shall be based on the same fee schedule that applies to these services when they are provided in the non-hospital setting. Services not covered or reimbursed as hospital services are as follows:

- a) Private Duty Nursing Services. Private duty nursing services for hospitalized program participants are not covered under the Medical Assistance Program. Hospitals are expected to provide all required nursing services.
- b) Sitter Services. Sitter services for hospitalized program participants are not covered under the Medical Assistance Program.
- c) Dental Services. Hospitals may not enroll to provide dental services. When dental services are provided in the outpatient/clinic setting of a hospital, the dentist shall submit charges to the Department according to the provisions of the Dental Program.
- d) Nurse Anesthetist Services. Payment for general anesthesia services not reimbursed under 89 Ill. Adm. Code 140.400 shall be made only to hospitals that qualify for these payments under the Medicare Program (~~Social Security Act, Title XVIII~~) and shall be made to such hospitals when provided by a hospital employed non-physician anesthetist (certified registered nurse anesthetist~~Certified Registered Nurse Anesthetist~~ or "CRNA").
- e) Pharmacy Services. Policy and reimbursement for pharmacy services are

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described in 89 Ill. Adm. Code 140.440 through 140.450. A hospital pharmacy may enroll on a fee-for-service basis for services provided to a patient in:

- 1) A specified bed or special hospital unit which is certified for skilled nursing facility services under the Medicare Program.
 - 2) A special hospital unit or separate facility which is administratively associated with the hospital and is licensed as a long term care facility.
 - 3) The outpatient/clinic setting when the services provided are not unique to the hospital setting.
- f) Medical Transportation Services. A hospital that owns and operates medical transportation vehicles as a separate entity (for example, a private corporation) must enroll as a medical transportation provider. A hospital that owns and operates medical transportation vehicles that are included on the hospital's cost report as a cost center of the hospital may not submit a separate claim for transportation services provided to persons admitted as inpatients. Policy and reimbursements for medical transportation services is described in 89 Ill. Adm. Code 140.490 through 140.492.
- g) Home Health Services. ~~Home health services are not considered by the Department to be hospital services.~~ A home health agency that is administratively associated with a hospital and that is certified for participation as a home health agency by the Medicare Program may apply for participation for the provision of home health services. Policy and reimbursement for home health services is described in 89 Ill. Adm. Code 140.470 through 140.474.
- h) Sub-acute Alcoholism and Substance Abuse Treatment Services. Only acute alcoholism and substance abuse treatment services (i.e., detoxification) are covered as hospital services. ~~Rules~~ Regulations regarding reimbursement for sub-acute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.
- i) Hospice Services. Hospice is an alternative to traditional Medicaid coverage. The Hospice Program is responsible for all the client's medical needs related to a terminal illness. If a client chooses the Hospice Program, a physician must certify that the client is terminally ill and has a life expectancy of six months or less.

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Policy and reimbursement for hospice services is described in 89 Ill. Adm. Code 140.469.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.70 Limitation On Hospital Services

Effective for dates of discharge on or after July 1, 2014:

- 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 148.105 through 148.115 and 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 ~~Part~~ 149.
- c) For hospitals, or distinct part units reimbursed on a per diem basis, under Sections 148.105 through 148.115 and 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.~~

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- ~~d)~~e) Payment for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Section 148.25(d)(1)~~89 Ill. Adm. Code 149.50(e)(1)~~, shall be made only when such services have been provided in accordance with federal regulations at 42 CFR 441, subparts C and D.
- ~~e)~~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.~~
- ~~f)~~g) ~~The 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 (~~f~~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.~~
- ~~1)2)~~ ~~The After the 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 by the amount that the payment on the claim is increased directly due to the occurrence of and treatment for a healthcare acquired condition~~the~~ (HAC).
- ~~2)3)~~ The Department shall not pay for services related to Other Provider Preventable Conditions (OPPCs).
- ~~3)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.
- ~~4)5)~~ Definitions. As used in this subsection (~~f~~g), the following terms are

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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 38 Ill. Reg. 15165, effective July 2, 2014)

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.82 Organ Transplant Services

Effective for dates of outpatient services on or after July 1, 2014 and inpatient discharges on or after July 1, 2014:

- a) Introduction
The Department ~~of Public Aid~~ will cover organ transplants as identified under subsection (b) ~~of this Section~~ that are provided to United States citizens or aliens who are lawfully admitted for permanent residence in the United States under color of law pursuant to 42 USC 1396a(a) and 1396b(v). ~~These~~ Such services must be provided by certified organ transplant centers ~~that~~ which meet the requirements specified in subsections (c) through (g) of this Section.
- b) Covered Services
- 1) Inpatient heart, heart/lung, lung (single or double), liver, pancreas or kidney/pancreas transplantation. Inpatient bone marrow transplants, inpatient and outpatient stem cell transplants.
 - 2) Inpatient intestinal (small bowel or liver/small bowel) transplantation for

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children only (see subsection (d)(1)(H) of this Section).

- 3) Other types of transplant procedures may be covered when a hospital has been certified by the Department as a transplant center eligible to perform such transplants. Centers must complete the certification process established in subsection (c) ~~of this Section~~ and provide the necessary documentation of the number of transplant procedures performed and the survival rates.
 - 4) Medically necessary work-up.
- c) Certification Process
- 1) In order to be certified to receive reimbursement for transplants performed on Medical Assistance ~~and KidCare~~ patients, the hospital must:
 - A) Request an application from the Bureau of Comprehensive Health Services.;
 - B) Submit a completed application to the Department for the type of transplant for which the center is seeking certification.;
 - C) Meet certification criteria established in subsection (d) ~~of this Section, based upon review and recommendation of each application by the State Medical Advisory Committee (SMAC); and~~
 - D) Submit a detailed status report on each patient for the type of transplant for which the hospital is seeking certification. The Such reports must include the patient's diagnosis, date of transplant, the length of hospitalization, charges, survival rates, patient-specific transplant outcome, and complications (including cause of death, if applicable) for all transplants performed in the time frames required for the type of transplant indicated in subsections (d)(1)(C), (D), (E), (F), (G), (H), (I) or (J) ~~of this Section~~. To protect the privacy of patients included in this report, names of patients who are not covered under Medical Assistance ~~or KidCare~~ are not required.

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- 2) The Department shall notify the hospital of approval or denial of the hospital as a transplant center for Medical Assistance ~~and KidCare~~ eligible patients.
 - 3) In the event the Department receives a request for prior approval to provide a service from a hospital not formally certified under this Section, the Department may approve the request if it determines that circumstances are such that the health, safety and welfare of the recipient would best be served by receiving the service at that hospital. In making its determination, the Department shall take into account the ~~ability and qualifications of the hospital~~ hospital's and its medical ~~staff's ability and qualifications~~ to provide the service, the burden on the recipient's family if a certified hospital is a great distance from their home, and the urgent nature of the transplant.
 - 4) A joint application combining the statistical data for the adult and pediatric programs from two affiliated hospitals that share the same surgeons may be submitted for review ~~by the State Medical Advisory Committee~~. The hospitals must meet the criteria under subsections (d)(1)(A), (B), (K), (L), (M), (N), (O), (P) and (Q), the applicable criteria under subsections (d)(1)(C), (D) or (J) and (d)(1)(R), subsections (d)(2), (3) and (4), and subsection (e) ~~of this Section~~ for certification and recertification.
- d) Certification Criteria
- 1) Hospitals seeking certification as a transplant center shall submit documentation to verify that:
 - A) The hospital is capable of providing all necessary medical care required by the transplant patient.;
 - B) The hospital is affiliated with an academic health center.;
 - C) The hospital has had the transplant program for inpatient adult heart and liver transplants in operation for at least three years with 12 transplant procedures per year for the past two years and 12

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cases in the three-year period preceding the most current two-year period for adult heart and liver transplants.

- D) The hospital has had the transplant program for inpatient adult heart/lung and lung transplants in operation for at least three years with ten transplant procedures per year for the past two years and ~~10~~ cases in the three-year period preceding the most current two-year period for adult heart/lung and lung transplants.
- E) A hospital specializing in inpatient pediatric heart/lung and lung transplants has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period.
- F) The hospital has had the transplant program for inpatient adult and pediatric bone marrow transplants in operation for at least two years with 12 transplant procedures per year for the past two years.
- G) The hospital performing outpatient adult and pediatric stem cell transplants must be part of a certified inpatient program and must have been in operation for at least two years with at least 12 outpatient stem cell transplant procedures per year in the past two years.
- H) A hospital specializing in inpatient pediatric heart or liver transplants, or both, has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period.
- I) A hospital specializing in inpatient pediatric intestinal (small bowel or liver/small bowel) transplants has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period.

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- J) A hospital specializing in inpatient kidney/pancreas and/or pancreas transplants has had the transplant program in operation for at least three years with 25 kidney transplant procedures per year for the past two years and 25 cases in the three-year period preceding the most current two-year period, and five pancreas transplant procedures per year for the past two years and five in the three year period preceding the most current two-year period, or 12 kidney/pancreas transplant procedures per year for the past two years and 12 in the three-year period preceding the most current two-year period.;
- K) The hospital has experts, on staff, in the fields of cardiology, pulmonology, anesthesiology, immunology, infectious disease, nursing, social services, organ procurement, associated surgery and internal medicine to complement the transplant team. In addition, in order to qualify as a transplant center for pediatric patients, the hospital must also have experts in the field of pediatrics.;
- L) The hospital has an active cardiovascular medical and surgical program as evidenced by the number of cardiac catheterizations, coronary arteriograms and open heart procedures per year for heart and heart/lung transplant candidates.;
- M) The hospital has pathology resources that are available for studying and reporting the pathological responses for transplantation as supported by appropriate documentation.;
- N) The hospital complies with applicable State and federal laws and regulations.;
- O) The hospital participates in a recognized national donor procurement program for organs or bone marrow provided by unrelated donors, abides by its rules, and provides the Department with the name of the national organization of which it is a member.;
- P) The hospital has an interdisciplinary body to determine the

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suitability of candidates for transplantation as supported by appropriate documentation.;

- Q) The hospital has blood bank support necessary to meet the demands of a certified transplant center as supported by appropriate documentation.;
- R) The hospital meets the applicable transplant survival rates as supported by the Kaplan-Meier method or other method accepted by the Department:
- i) A one-year survival rate of 50 percent for inpatient bone marrow and inpatient and outpatient stem cell transplant patients.;
 - ii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for heart transplant patients.;
 - iii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for liver transplant patients.;
 - iv) A one-year survival rate of 90 percent for kidney transplant and a one-year survival rate of 80 percent for pancreas transplant; or a one-year survival rate of 80 percent for kidney/pancreas transplant.;
 - v) A one-year survival rate of 65 percent and a two-year survival rate of 60 percent for heart/lung and lung (single or double) transplant patient.;
 - vi) A one-year survival rate of 60 percent and a two-year survival rate of 55 percent for intestinal transplants (small bowel or liver/small bowel).
- 2) The commitment of the hospital to support the transplant center must be at all levels as evidenced by such factors as financial resources, allocation of space and the support of the professional staff for the transplant program and its patients. The hospital must submit appropriate documentation to

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demonstrate that:

- A) Component teams are integrated into a comprehensive transplant team with clearly defined leadership and responsibility.
 - B) The hospital safeguards the rights and privacy of patients.
 - C) The hospital has adequate patient management plans and protocols to meet the patient and hospital's needs.
- 3) The hospital must identify, in writing, the director of the transplant program and the members of the team as well as their qualifications. Physician team members must be identified as board certified, in preparation for board certification, or pending board certification, and the transplant coordinator's name must be submitted.
- 4) The hospital must provide patient selection criteria including indications and contraindications for the type of transplant procedure for which the facility is seeking certification.
- e) Recertification Process/Criteria
- 1) The Department will conduct an annual review for certification of transplant centers. A certified center must submit documentation established under subsections (c), (d), (f) and ~~(g)(h) of this Section for review by the Department's State Medical Advisory Committee~~ for recertification as a transplant center.
 - 2) Survival rates of previous transplant patients must be documented prior to certification. The center must maintain patient volume in the year of certification based on previous transplant statistics.
 - 3) The Department shall notify the hospital of approval or denial of the recertification of the hospital as a transplant center.
 - 4) If the hospital has previously met the requirements for certification or recertification of its program under subsections (d)(1)~~(K), (K)-(L)~~, (M), (N), (O), (P) and (Q) and (d)(2), (3) and (4) ~~of this Section~~ and the

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program has experienced no changes under the above subsections, as evidenced in written documentation on the hospital's application, the hospital will not be required to resubmit the same data.

- 5) If a center has previously met the requirements for certification or recertification of its program under subsections (d)(1) (K), (L), (M), (N), (O), (P), (Q) and (R)(i) through (R)(vi), but has performed fewer than the required number of transplants pursuant to subsections (d)(1)(C), (D), (E), (F), (G), (H), (I) or (J) as appropriate, the Department may recertify the center if it determines that the best interests of the Medical Assistance ~~or KidCare~~ client eligible for transplant services would be served by allowing continued certification of the center. Criteria the Department may consider in making such a determination include, but are not limited to:
 - A) Not recertifying a center would limit the accessibility of available organs.
 - B) Other centers are not accepting new patients or have extensive waiting lists.
 - C) The distance to other eligible centers would jeopardize the client's opportunity to receive a viable organ/tissue transplant.
- f) Notification of Transplant
 - 1) The hospital must notify the Department prior to performance of the transplant procedure. The notification letter must be from a physician on the transplant team.
 - 2) The notification must include the admission diagnosis and pre-transplant diagnosis.
 - 3) The Department shall notify the hospital regarding receipt of the notification and provide the appropriate outcome summary forms to the hospital.
- g) ~~Reimbursement~~

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- 1) ~~Hospital services rendered for transplant procedures under this Section are exempt from the provisions of Sections 148.250 through 148.330 and 89 Ill. Adm. Code 149 of the Department's administrative rules governing hospital reimbursement. Hospital reimbursement for transplants covered within this Section is an all-inclusive rate for the admission, regardless of the number of days of care associated with that admission, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for a maximum number of days listed below for specific types of transplants:~~
 - A) ~~30 consecutive days of post-operative inpatient care for heart, heart/lung, lung (single or double), pancreas, or kidney/pancreas transplant; or~~
 - B) ~~40 consecutive days of post-operative inpatient care for liver transplant; or~~
 - C) ~~50 consecutive days of post-operative inpatient care for bone marrow transplant (this includes a maximum of seven days prior to the transplant for infusion of chemotherapy), or 50 consecutive days of care for an inpatient or outpatient stem cell transplant; or~~
 - D) ~~70 consecutive days of post-operative inpatient care for intestinal (small bowel or liver/small bowel) transplants; or~~
 - E) ~~For those transplants covered under subsection (b)(2) of this Section, the number of consecutive days of inpatient care specified within the transplant certification process.~~
- 2) ~~Reimbursement will be approved only when the Department's letter acknowledging the notification of the transplant procedure is attached to the hospital's claim. Reimbursement will not be made until the discharge summary has been submitted to the Department.~~
- 3) ~~Applicable disproportionate share payment adjustments shall be made in accordance with Section 148.120(g). Applicable outlier adjustments shall be made in accordance with Section 148.130. Applicable Medicaid High Volume adjustments shall be made in accordance with Section 148.290(d).~~

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- 4) ~~The rate will not include transportation and physician fees when reimbursed pursuant to 89 Ill. Adm. Code 140.410 through 140.414 and 140.490 through 140.492, respectively.~~
- 5) ~~Hospital reimbursement for bone marrow searches is limited to 60 percent of charges up to a maximum of \$25,000. Payment for bone marrow searches will only be made to the certified center requesting reimbursement for the bone marrow transplant.~~
- 6) ~~Reimbursement for stem cell acquisition charges which includes the mobilization, chemotherapy, cytokines and apheresis processes must be billed under the appropriate revenue code on the claim submitted for the transplant procedure.~~

~~g)h)~~ Reporting Requirements of Certified Transplant Center

The following documentation must be submitted within the time limits set forth in this subsection (~~gh~~).

- 1) Outcome Summary
 - A) The discharge summary for each Medical Assistance ~~and KidCare~~ patient must be received by the Department within 30 days after the patient's discharge.
 - B) For those Medical Assistance ~~and KidCare~~ patients who expire, a summary must be received by the Department within 30 days after the patient's death.
- 2) Notification of Changes
The center must notify the Department within 30 days after any changes in its program including, but not limited to, certification criteria, patient selection criteria, members of the transplant team and the coordinator.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.85 Supplemental Tertiary Care Adjustment Payments (Repealed)

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- a) ~~Qualifying Criteria. Supplemental Tertiary Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to all qualifying Illinois hospitals. An Illinois hospital shall qualify for payment if it was deemed eligible for payments under the Tertiary Care Adjustment Payments for State fiscal year 2003, as described in Section 148.296, excluding:~~
- ~~1) County-owned hospitals as described in Section 148.25(b)(1)(A).~~
 - ~~2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).~~
 - ~~3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~
- b) ~~Supplemental Tertiary Care Adjustment Payments~~
- ~~1) For the supplemental tertiary care adjustment period occurring in State fiscal year 2004, total payments will equal the State fiscal year 2003 tertiary care adjustment payment, as defined in Section 148.296, multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (d) of this Section have been met.~~
 - ~~2) For the supplemental tertiary care adjustment period occurring in State fiscal year 2005, total payments will equal the State fiscal year 2003 tertiary care adjustment payment, as defined in Section 148.296 and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (d) being met, shall be paid within 75 days after the conditions described in subsection (d) have been met.~~
 - ~~3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~
- e) ~~Definitions~~

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- 1) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- 2) ~~"Supplemental Tertiary Care Adjustment Period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
- d) ~~Payment Limitations: Payments under this Section are not due and payable until:~~
 - 1) ~~the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~
 - 2) ~~the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and~~
 - 3) ~~the assessment described in 89 Ill. Adm. Code 140.80 is in effect.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.90 Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments
(Repealed)

- a) ~~Qualifying Criteria. Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments as described in subsection (b) of this Section shall be made to an Illinois hospital, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).~~
- b) ~~MIUR Adjustment Payments~~
 - 1) ~~Each qualifying hospital will receive a payment equal to the product of:~~
 - A) ~~The quotient of:~~
 - i) ~~\$57.25~~
 - ii) ~~divided by the greater of the hospital's MIUR or 1.6 percent, and~~

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~~B) The hospital's Medicaid inpatient days in the MIUR base period.~~

~~2) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~

~~3) Payments will be the lesser of the calculation described in subsection (b)(1) or (b)(2) of this Section or \$10,500,000.~~

~~e) Payment to a Qualifying Hospital~~

~~1) For the MIUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.~~

~~2) For the MIUR adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (e) being met, shall be paid within 75 days after the conditions described in subsection (e) have been met.~~

~~3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

~~d) Definitions~~

~~1) "MIUR base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~

~~2) "MIUR adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and~~

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~~beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~

- 3) ~~"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 that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the MIUR base period that were adjudicated by the Department through June 30, 2002.~~
- 4) ~~"MIUR", for a given hospital, has the meaning as defined in Section 148.120(k)(4) 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 2003 shall be the MIUR used in the MIUR adjustment.~~
- 5) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, 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.~~
- 6) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~

e) ~~Payment Limitations: Payments under this Section are not due and payable until:~~

- 1) ~~the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~
- 2) ~~the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and~~

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~~3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.95 Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments
(Repealed)

- ~~a) Qualifying Criteria. Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments, as described in subsection (b) of this Section, shall be made to an Illinois hospital, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).~~
- ~~b) MOUR Adjustment Payments~~
- ~~1) Each qualifying hospital will receive a payment equal to the product of:~~
- ~~A) The quotient of:~~
- ~~i) the hospital's Medicaid outpatient charges in the MOUR base period~~
- ~~ii) divided by the greater of the hospital's MOUR or 1.6 percent, and~~
- ~~B) 2.45 percent.~~
- ~~2) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~
- ~~3) Payments will be the lesser of the calculation described in subsection (b)(1) or (b)(2) of this Section or \$6,750,000.~~
- ~~e) Payment to a Qualifying Hospital~~

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- 1) ~~For the MOUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.~~
 - 2) ~~For the MOUR adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (e) being met, shall be paid within 75 days after the conditions in subsection (e) have been met.~~
 - 3) ~~If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~
- d) Definitions
- 1) ~~"Total outpatient charges" means, for a given hospital, the gross outpatient revenue as reported on form CMS 2552-96, Worksheet G-2, Part I, row 25, column 2, for hospital fiscal years ending in calendar year 2001 as filed in the March 2003 release of the Healthcare Cost Reporting Information System (HCRIS). If information was not available for hospitals on the HCRIS, the Department may obtain the gross outpatient charges 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) ~~"MOUR base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
 - 3) ~~"MOUR adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12 month period beginning July 1 of the year and ending June 30 of the following year.~~

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- 4) ~~"MOUR", for a given hospital, means the ratio of Medicaid outpatient charges to total outpatient charges.~~
- 5) ~~"Medicaid outpatient charges" means, for a given hospital, the sum of charges for ambulatory procedure listing services as described in Section 148.140(b), excluding charges for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover charges), as tabulated from the Department's paid claims data for services occurring in the MOUR base year that were adjudicated by the Department through September 12, 2003.~~
- 6) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department of Public Aid 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.~~
- 7) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- e) ~~Payment Limitations: Payments under this Section are not due and payable until:~~
 - 1) ~~the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~
 - 2) ~~the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and~~
 - 3) ~~the assessment described in 89 Ill. Adm. Code 140.80 is in effect.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

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Section 148.100 County Trauma Center~~Outpatient Rural Hospital~~ Adjustment Payments

Effective for dates of service on or after July 1, 2014:

- a) County Trauma Center Adjustment (TCA) Payments. Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by DPH, shall receive an adjustment that shall be calculated as follows: ~~Qualifying Criteria. Outpatient Rural Hospital Adjustment Payments, as described in subsection (b) of this Section, shall be made to qualifying Illinois rural hospitals, as described in Section 148.25(g)(3), excluding:~~
- 1) The available funds from the Trauma Center Fund each quarter shall be divided by the number of each eligible hospital's (as defined in subsection (a)(4)) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter. ~~County-owned hospitals as described in Section 148.25(b)(1)(A).~~
 - 2) The TCA payments shall not be treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Illinois Public Aid Code. ~~Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).~~
 - 3) The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis. ~~A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~
 - 4) Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this Section shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by DPH, or the appropriate licensing agency, as a Level I or Level II trauma center as required for the adjustments described in subsection (a)(1). In these instances, the adjustments calculated under this subsection (a)(4) shall be pro-rated as applicable, based upon the date that recognition ceased.

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b) Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments in this Section are as follows: ~~Outpatient Rural Hospital Adjustment Payments~~

- 1) ~~"Available funds" means funds that have been deposited into the Trauma Center Fund, have been distributed to the Department by the State Treasurer, and have been appropriated by the Illinois General Assembly. Each qualifying hospital's outpatient services for the outpatient rural base period will be divided by the sum of all qualifying hospitals' outpatient services for the outpatient rural base period.~~
- 2) ~~"Medicaid trauma admission" means for, discharges through June 30, 2014, those services provided to Medicaid-enrolled beneficiaries that were received and processed as hospital inpatient admissions, excluding admissions for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: This ratio will be multiplied by \$14,500,000 to determine the hospital's Outpatient Rural Hospital Adjustment Payment.~~

~~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 839.3; 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; 926.8; 929.0 through 929.99; 958.4; 958.5; 990 through 994.99.~~

~~For discharges after June 30, 2014, those services provided to Medicaid-enrolled beneficiaries that were received and processed as hospital~~

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inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, and have been grouped to one of the following DRGs:

020 Craniotomy for trauma.

055 Head trauma, with coma lasting more than one hour or hemorrhage.

056 Brain contusion/laceration and complicated skull fracture, coma less than one hour or no coma.

057 Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.

135 Major chest and respiratory trauma.

308 Hip and femur procedures for trauma, except joint replacement.

384 Contusion, open wound and other trauma to skin and subcutaneous tissue.

910 Craniotomy for multiple significant trauma.

911 Extensive abdominal/thoracic procedures for multiple significant trauma.

912 Musculoskeletal and other procedures for multiple significant trauma.

930 Multiple significant trauma, without operating room procedure.

- 3) "TCA base period" means the 12-month period ending on the last day of June preceding the TCA rate period. For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(2) of this

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~~Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~

- 4) ~~"TCA rate period" means the 12-month period beginning on October 1 of the year and ending September 30 of the following year.~~
- 5) ~~"Trauma Center Fund" means the fund created in the State treasury by Section 5.325 of the State Finance Act [30 ILCS 105] and described in Section 3.225 of the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] and Section 5-5.03 of the Public Aid Code.~~

e) ~~Payment to a Qualifying Hospital~~

- 1) ~~For the outpatient rural hospital adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.~~
- 2) ~~For the outpatient rural hospital adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (e) being met, shall be paid within 75 days after the conditions described in subsection (e) have been met.~~
- 3) ~~If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

d) ~~Definitions~~

- 1) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed~~

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- ~~days is not reported on the Annual Survey of Hospitals, 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) ~~"Outpatient rural base period" means the 12-month period beginning on July 1, 2000, and ending on June 30, 2001.~~
- 3) ~~"Outpatient rural adjustment period" means, beginning June 1, 2004, the one-month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
- 4) ~~"Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b), excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid claims data for services occurring in the outpatient rural base period that were adjudicated by the Department through September 12, 2003.~~
- 5) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- e) ~~Payment Limitations: Payments under this Section are not due and payable until:~~
- 1) ~~the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~
- 2) ~~the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and~~
- 3) ~~the assessment described in 89 Ill. Adm. Code 140.80 is in effect.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

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Section 148.103 Outpatient Service Adjustment Payments (Repealed)

- a) ~~Qualifying Criteria. Outpatient Service Adjustment Payments, as described in subsection (b) of this Section, shall be made to all Illinois hospitals excluding:~~
- ~~1) County-owned hospitals as described in Section 148.25(b)(1)(A).~~
 - ~~2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).~~
 - ~~3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~
- b) ~~Outpatient Service Adjustment Payments~~
- ~~1) An average hospital-specific outpatient service rate for the outpatient service base period will be calculated by taking the total payments for outpatient services divided by total outpatient services.~~
 - ~~2) The average hospital-specific outpatient service rate will be multiplied by 75.5 percent and then multiplied by the outpatient services.~~
 - ~~3) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(2) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~
 - ~~4) Outpatient Service Adjustment Payments will be the lesser of the amount determined in subsection (b)(2) or (b)(3) of this Section or \$3,000,000.~~
- e) ~~Payment to a Qualifying Hospital~~
- ~~1) For the outpatient service adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to~~

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~~the hospital within 75 days after the conditions in subsection (e) of this Section have been met.~~

- ~~2) For the outpatient service adjustment period occurring in State fiscal year 2005, total annual payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions in subsection (e) being met, shall be paid within 75 days after the conditions in subsection (e) have been met.~~
- ~~3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

d) Definitions

- ~~1) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, 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) "Outpatient service base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
- ~~3) "Outpatient service adjustment period" means, beginning June 1, 2004, the one-month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
- ~~4) "Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b), excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated~~

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~~from the Department's paid claims data for services occurring in the outpatient service base period that were adjudicated by the Department through September 12, 2003.~~

- 5) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- e) ~~Payment Limitations: Payments under this Section are not due and payable until:~~
- 1) ~~the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~
 - 2) ~~the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and~~
 - 3) ~~the assessment described in 89 Ill. Adm. Code 140.80 is in effect.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.105 Reimbursement Methodologies for Inpatient Rehabilitation Services~~Psychiatric Adjustment Payments~~

Effective with discharges on or after July 1, 2014:

- a) Inpatient rehabilitation services not excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b) shall be reimbursed through the DRG PPS.
Qualifying Criteria
~~Psychiatric Adjustment Payments shall be made to a qualifying hospital, as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria as of July 1, 2002:~~
- 1) ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; and has~~

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~~a MIUR as described in subsection (e)(5) of this Section that is greater than 60 percent.~~

- 2) ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA-6; has a MIUR as described in subsection (e)(5) that is greater than 20 percent; has greater than 325 total licensed beds as described in subsection (e)(2) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 50 percent.~~
- 3) ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA-6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 15 percent; has greater than 500 total licensed beds as described in subsection (e)(2) of this Section; has a psychiatric occupancy rate as described in subsection (e)(4) of this Section that is greater than 35 percent; and has total licensed psychiatric beds described in subsection (e)(3) of this Section that is greater than 50.~~
- 4) ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA-6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 19 percent; has less than 275 total licensed beds as described in subsection (e)(2) of this Section; has fewer than 1,000 total psychiatric care days as described in subsection (e)(8) of this Section; has 40 or fewer total licensed psychiatric beds as described in subsection (e)(3) of this Section; has greater than 6,000 total days as described in subsection (e)(9) of this Section.~~

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- ~~5) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the Statewide psychiatric distinct part unit average default rate; is located outside of HSA-6; has 50 or more total licensed psychiatric beds as described in subsection (e)(3) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 60 percent.~~
- b) Inpatient rehabilitation services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to subsection (c) or (d), as applicable. The total payment for an inpatient stay will equal the sum of:
- ~~1) the payment determined in this Section; and~~
 - ~~2) any applicable adjustments to payment specified in Section 148.290. The following five classes of hospitals are ineligible for Psychiatric Adjustment Payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4) of this Section:~~
 - ~~1) Hospitals located outside of Illinois.~~
 - ~~2) Hospitals located inside HSA-6.~~
 - ~~3) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(e)(1).~~
 - ~~4) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(e)(4).~~
 - ~~5) A children's hospital, as described in 89 Ill. Adm. Code 149.50(e)(3).~~
- c) Rehabilitation Hospital. Payment for inpatient rehabilitation services provided by a rehabilitation hospital, as defined in Section 148.25(d)(2): Psychiatric Adjustment Payment Rates
- 1) For which the Department had no inpatient base period claims data, shall be the product of the following:

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- A) 80 percent of weighted average rehabilitation hospital rate; and
- B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i). For a hospital qualifying under subsection (a)(1) of this Section, the rate is \$63.00.
- 2) For which the Department had inpatient base period claims data, shall be the product of the following: For a hospital qualifying under subsection (a)(2) of this Section that:
- A) The greater of: Has less than 10,000 total days, the rate is \$78.00.
- i) the hospital's rehabilitation rate, as determined in subsection (e); and
- ii) 80 percent of the weighted average rehabilitation hospital rate.
- B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i) Has equal to or greater than 10,000 total days, the rate is \$125.00.
- 3) For a hospital qualifying under subsection (a)(3) of this Section, the rate is \$21.00.
- 4) For a hospital qualifying under subsection (a)(4) of this Section, the rate is \$38.00.
- 5) For a hospital qualifying under subsection (a)(5) of this Section, the rate is \$140.00
- d) Distinct Part Rehabilitation Unit. Payment for inpatient rehabilitation services provided by a distinct part rehabilitation unit, as defined in Section 148.25(c)(2): Payment to a Qualifying Hospital
- 1) For which the Department had no inpatient base period paid claims data, shall be the product of the following: The total annual adjustment amount to a qualifying hospital shall be the product of the appropriate psychiatric

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~~adjustment payment rate, as described in subsection (e) of this Section, multiplied by total days as described in subsection (e)(9) of this Section.~~

A) The arithmetic mean rate for rehabilitation distinct part units.

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

2) For which the Department had inpatient base period paid claims data, shall be the product of the following:~~The total annual adjustment amount shall be paid to the hospital during the Psychiatric Adjustment Payment period in installments on at least a quarterly basis.~~

A) The lesser of:

i) The greater of:

- The distinct part rehabilitation unit rate, as determined in subsection (e); and
- 80 percent of the arithmetic mean rate for rehabilitation distinct part units.

ii) The arithmetic mean rehabilitation rate for rehabilitation distinct part units plus the value of one standard deviation of the rehabilitation rate for rehabilitation distinct part units.

e) The rehabilitation rate is calculated as the sum of:

1) The rehabilitation rate in effect on July 1, 2011.

2) The quotient, rounded to the nearest hundredth, of the rehabilitation provider's allocated static payments divided by the rehabilitation provider's inpatient covered days in the inpatient base period paid claims data.

f)e) Definitions

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"Allocated static payments" means the adjustment payments made to the hospital pursuant to 89 Ill. Adm. Code 148.105, 148.115, 148.126, 148.295, 148.296 and 148.298, during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies outlined in rule as of February 21, 2014 (see <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>), as determined by the Department, allocated to rehabilitation services based on the ratio of rehabilitation claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Inpatient base period paid claims data" means SFY 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for rehabilitation payment for services provided in SFY 2015 and 2016.

"Weighted average rehabilitation hospital rate" means the sum of rehabilitation hospital inpatient base period paid claims data total reported payments, excluding Disproportionate Share Hospitals (DSH) and Medicaid Percentage Adjustment/Medicaid High Volume Adjustment (MPA/MHVA), plus rehabilitation hospital total allocated supplemental payments, divided by rehabilitation hospital inpatient base period paid claims data total covered days.

- 1) ~~"HSA" means Health Service Area, as defined by the Illinois Department of Public Health.~~
- 2) ~~"Total 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".~~
- 3) ~~"Licensed psychiatric beds" means, for a given hospital, the number of psychiatric licensed 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".~~
- 4) ~~"Psychiatric occupancy rate" means, for a given hospital, the psychiatric hospital occupancy rate 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".~~

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- 5) ~~"MIUR" for a given hospital, has the meaning as defined in Section 148.120(k)(5), and shall be determined in accordance with Sections 148.120(c) and (f). For purposes of this rulemaking, 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 Psychiatric Adjustment Payments in the Psychiatric Adjustment Payment Period.~~
- 6) ~~"Psychiatric Adjustment Payment base year" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
- 7) ~~"Psychiatric Adjustment Payment period" means, beginning October 1, 2002, the nine-month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
- 8) ~~"Total psychiatric care days" means, for a given hospital, the sum of days of inpatient psychiatric care, as defined in Section 148.40(a), 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 Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.~~
- 9) ~~"Total days" means, for a given hospital, the sum of days of inpatient hospital services 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 Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.~~
- 10) ~~"Psychiatric care average length of stay" means the quotient of the fraction, the numerator of which is the number of psychiatric care days in the Psychiatric Adjustment Payment base year, the denominator of which~~

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~~is the number of admissions in the Psychiatric Adjustment Payment base year.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.110 Reimbursement Methodologies for Inpatient Psychiatric Services Base Rate Adjustment Payments

Effective for dates of discharge on or after July 1, 2014:

- a) Inpatient psychiatric services not excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b) shall be reimbursed through the DRG PPS Qualifying Criteria
- 1) ~~Psychiatric Base Rate Adjustment Payments, as described in subsection (b)(1) of this Section, shall be made to an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding:~~
- A) ~~County-owned hospitals as described in Section 148.25(b)(1)(A).~~
- B) ~~Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).~~
- C) ~~A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~
- 2) ~~Psychiatric Base Rate Adjustment Payments described in subsection (b)(2) of this Section shall be made to an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).~~
- b) Inpatient psychiatric services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to subsection (c), (d) or (g), as applicable. The total payment for an inpatient stay will equal the sum of:
- 1) the payment determined in this Section; and

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- 2) any applicable adjustments to the payment specified in Section 148.290. Psychiatric Base Rate Adjustment Payments
- 1) ~~For a hospital qualifying under subsection (a)(1) of this Section, the Department shall pay an amount equal to \$400.00 less the hospital's per diem rate for Medicaid inpatient psychiatric services in effect on October 1, 2003, multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric base rate period. In no event, however, shall that amount be less than zero.~~
- 2) ~~For a hospital qualifying under subsection (a)(2) of this Section, whose inpatient psychiatric per diem rate in effect on October 1, 2003 is greater than \$400.00, the Department shall pay an amount equal to \$25.00 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric base rate period.~~
- 3) ~~For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) or (b)(2) shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~
- c) Psychiatric Hospital. Payment for inpatient psychiatric services provided by a psychiatric hospital, as defined in Section 148.25(d)(1): Payment to a Qualifying Hospital
 - 1) For psychiatric hospitals not enrolled with the Department on June 30, 2014, shall be the product of: For the psychiatric base rate adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (f) of this Section have been met.
 - A) The lowest hospital psychiatric rate determined pursuant to subsection (e); and
 - B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

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2) For psychiatric hospitals enrolled with the Department on June 30, 2014, shall be the product of:

A) The hospital's psychiatric rate, as determined in subsection (e).

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

~~For the psychiatric base rate adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (f) being met, shall be paid within 75 days after the conditions in subsection (f) have been met.~~

3) ~~If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

d) Distinct Part Psychiatric Unit. Payment for psychiatric services provided by a distinct part psychiatric unit, as defined in Section 148.25(c)(1): Limitations: Hospitals that qualify for Psychiatric Base Rate Adjustment Payments shall not be eligible for the total Psychiatric Base Rate Adjustment Payment if, during the psychiatric base rate adjustment period, the hospital no longer operates the psychiatric distinct part unit.

1) For which the Department had no inpatient base period paid claims data, shall be the product of the following:

A) 80 percent of the arithmetic mean transition rate for psychiatric distinct part units; and

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

2) For which the Department had inpatient base period paid claims data, shall be the product of the following:

A) The lesser of:

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- i) The greater of:
- The distinct part psychiatric unit rate, as determined in subsection (e); and
 - 80 percent of the arithmetic mean psychiatric rate for psychiatric distinct part units.
- ii) The arithmetic mean rate for psychiatric distinct part units plus the value of two standard deviations of the psychiatric rate for psychiatric distinct part units.
- e) The psychiatric rate is calculated as the sum of:
- 1) The per diem rate for psychiatric services in effect on June 30, 2014.
 - 2) The quotient, rounded to the nearest hundredth, of the psychiatric provider's allocated static payments divided by the psychiatric provider's inpatient covered days in the inpatient base period paid claims data.
- f) Definitions
- "Allocated static payments" means the adjustment payments made to the hospital pursuant to Sections 148.105, 148.115, 148.126, 148.295, 148.296 and 148.298 during the SFY 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies outlined in rule as of February 21, 2014 (see <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>), as determined by the Department, allocated to psychiatric services based on the ratio of psychiatric claim charges to total inpatient claim charges determined using inpatient base period claims data.
- "Inpatient base period paid claims data" means SFY 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for psychiatric payment for services provided in SFY 2015 and 2016.
- g) Psychiatric hospital adjustors for dates of service beginning July 1, 2014 through June 30, 2018. For Illinois freestanding psychiatric hospitals, defined in Section

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148.25(d)(1), that were not children's hospitals as defined in Section 148.25(d)(3) in FY 2013 and whose Medicaid covered days were 90% or more for individuals under 20 years of age in FY 2013, the Department shall pay a per day add-on of \$48.25.

- 1) ~~"Psychiatric base rate period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
- 2) ~~"Psychiatric base rate adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
- 3) ~~"Medicaid inpatient psychiatric days" means, for a given hospital, the sum of days of inpatient psychiatric 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 paid claims data for admissions occurring in the psychiatric base period that were adjudicated by the Department through June 30, 2002.~~
- 4) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, 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.~~
- 5) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- f) ~~Payment Limitations: Payments under this Section are not due and payable until:~~

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- 1) ~~the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~
- 2) ~~the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and~~
- 3) ~~the assessment described in 89 Ill. Adm. Code 140.80 is in effect.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.112 Medicaid High Volume Adjustment Payments

Effective for dates of service on or after July 1, 2014:

- a) ~~The Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals that are eligible to receive the adjustment payments described in Section 148.122. Qualifying criteria. High Volume Adjustment Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it did not qualify for disproportionate share adjustments as described in Section 148.120 for the rate year 2003 determination and provided more than 20,000 Medicaid inpatient days in the high volume base period.~~
- b) ~~Calculation of Medicaid High Volume Adjustments~~The following classes of hospitals are ineligible for High Volume Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) ~~A children's hospital, as defined in Section 148.25(d)(3), shall receive an MHVA payment adjustment of \$120. County-owned hospitals as described in Section 148.25(b)(1)(A).~~
 - 2) ~~Any hospital other than a children's hospital meeting the criteria specified in subsection (a) shall receive an MHVA payment adjustment of \$60. Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).~~

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- 3) ~~The amount calculated pursuant to subsections (b)(1) and (b)(2) shall be adjusted as authorized in Section 5-5.02 of the Illinois Public Aid Code. A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~
- c) ~~Payment High Volume Adjustment Payments 1) The adjustments calculated under this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided so long as the hospital meets the criteria specified in subsection (a) on the covered day. For a hospital qualifying under subsection (a) of this Section, the Department shall pay the product of \$190.00 multiplied by the qualifying hospital's Medicaid inpatient days.~~
- 2) ~~For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (c)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~
- 3) ~~For hospitals qualifying under subsection (a) of this Section that provided fewer than 30,000 Medicaid inpatient days in the high volume base period, payments will be the lesser of the calculation described in subsection (c)(1) or (c)(2) of this Section or \$3,500,000.~~
- d) ~~Payment to a Qualifying Hospital~~
- 1) ~~For the high volume adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (c) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (f) of this Section have been met.~~
- 2) ~~For the high volume adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions in~~

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- ~~subsection (f) being met, shall be paid within 75 days after the conditions in subsection (f) have been met.~~
- 3) ~~If a hospital closes during fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~
- e) Definitions
- 1) ~~"High volume base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
- 2) ~~"High volume adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
- 3) ~~"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 that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the high volume base period that were adjudicated by the Department through June 30, 2002.~~
- 4) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, 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.~~
- 5) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- f) ~~Payment Limitations: Payments under this Section are not due and payable until:~~

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- 1) ~~the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~
- 2) ~~the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and~~
 - 3) ~~the assessment described in 89 Ill. Adm. Code 140.80 is in effect.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.115 Reimbursement Methodologies for Long Term Acute Care Services~~Rural Adjustment Payments~~

Effective with discharges on or after July 1, 2014:

- a) Inpatient long term acute care psychiatric services excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b) shall be reimbursed under the inpatient psychiatric services methodologies specified in Section 148.110.~~Qualifying Criteria~~
~~Rural Adjustment Payments shall be made to all qualifying general acute care hospitals that are designated as a Critical Access Hospital or a Necessary Provider, as designated by the Illinois Department of Public Health, in accordance with 42 CFR 485, Subpart F (2001), as of the first day of July in the Rural Adjustment Payment rate period.~~
- b) Inpatient long term acute care services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to this Section. The total payment for an inpatient stay will equal the sum of:
 - 1) the payment determined in this Section; and
 - 2) any applicable adjustments to payment specified in Section 148.290.~~Rural Adjustment Rates~~
 - 4) ~~Inpatient Component~~

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~~For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment inpatient component shall be calculated as follows:~~

- ~~A) Total inpatient payments, as described in subsection (d)(2) of this Section, shall be divided by the total inpatient days, as described in subsection (d)(4) of this Section, to derive an inpatient payment per day.~~
- ~~B) Total inpatient charges, associated with inpatient days as described in subsection (d)(4) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total inpatient cost.~~
- ~~C) Total inpatient costs, as defined in subsection (b)(1)(B) of this Section, are divided by the total inpatient days, as described in subsection (d)(4) of this Section, to derive an inpatient cost per day.~~
- ~~D) Inpatient payment per day, as defined in subsection (b)(1)(A) of this Section, shall be subtracted from the inpatient cost per day, as described in subsection (b)(1)(C) of this Section, to derive an inpatient cost coverage deficit per day. The minimum result shall be no lower than zero.~~
- ~~E) Inpatient cost coverage deficit per day, as described in subsection (b)(1)(D) of this Section, shall be multiplied by the total inpatient days, as described in subsection (d)(4) of this Section, to derive a total hospital specific inpatient cost coverage deficit.~~
- ~~F) The inpatient cost deficits, as described in subsection (b)(1)(E) of this Section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year inpatient cost deficit.~~

2) **Outpatient Component**

~~For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment outpatient component shall be calculated as follows:~~

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- A) ~~Total outpatient payments, as defined in subsection (d)(3) of this Section, shall be divided by the total outpatient services, as described in subsection (d)(5) of this Section, to derive an outpatient payment per service unit.~~
- B) ~~Total outpatient charges, associated with outpatient services, as defined in subsection (d)(5) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total outpatient cost.~~
- C) ~~Total outpatient costs, as defined in subsection (b)(2)(B) of this Section, are divided by the total outpatient services, as described in subsection (d)(5) of this Section, to derive an outpatient cost per service unit.~~
- D) ~~Outpatient payment per service unit, as defined in subsection (b)(2)(A) of this Section, shall be subtracted from the outpatient cost per service unit, as described in subsection (b)(2)(C) of this Section, to derive an outpatient cost coverage deficit per service unit. The minimum result shall be no lower than zero.~~
- E) ~~Outpatient cost coverage deficit per service unit, as described in subsection (b)(2)(D) of this Section, shall be multiplied by the total outpatient services, as described in subsection (d)(5) of this Section, to derive a total hospital specific outpatient cost coverage deficit.~~
- F) ~~The outpatient cost coverage deficits, as described in subsection (b)(2)(e) of this Section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year outpatient cost deficit.~~
- 3) **Payment Methodology**
A \$7 million total pool shall be allocated to the program, and proportioned between inpatient services and outpatient services as follows:
- A) ~~The total inpatient cost coverage deficit, as described in subsection (b)(1)(F) of this Section, is added to the total outpatient cost~~

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~~coverage deficit, as described in subsection (b)(2)(F) of this Section, to derive a total Rural Adjustment Payment base year deficit.~~

- B) ~~The inpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total inpatient cost deficit, as described in subsection (b)(1)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.~~
- C) ~~The outpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total outpatient cost deficit, as described in subsection (b)(2)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.~~
- D) ~~An inpatient pool allocation shall be the product of the inpatient pool allocation percentage, as described in subsection (b)(3)(B) of this Section, multiplied by the \$7 million pool, as described in subsection (b)(3) of this Section.~~
- E) ~~The outpatient pool allocation shall be the product of the outpatient pool allocation percentage, as described in subsection (b)(3)(C) of this Section, multiplied by the \$7 million pool, as described in subsection (b)(3) of this Section.~~
- F) ~~An inpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the inpatient pool allocation, as described in subsection (b)(3)(D) of this Section, the denominator of which shall be the total inpatient cost deficit as described in subsection (b)(1)(F) of this Section.~~
- G) ~~An outpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the outpatient pool allocation, as described in subsection (b)(3)(E) of this Section, the denominator of which shall be the total outpatient cost deficit as described in subsection (b)(2)(F) of this Section.~~

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- H) ~~The hospital-specific inpatient cost coverage adjustment amount shall be the product of the inpatient residual cost coverage factor, as described in subsection (b)(3)(F) of this Section, multiplied by the hospital-specific inpatient cost coverage deficit, as described in subsection (b)(1)(E) of this Section.~~
- I) ~~The hospital-specific outpatient cost coverage adjustment amount shall be the product of the outpatient residual cost coverage factor, as described in subsection (b)(3)(G) of this Section, multiplied by the hospital-specific outpatient cost coverage deficit, as described in subsection (b)(2)(E) of this Section.~~
- c) Payment for long term acute care services provided by a long term acute care hospital, as defined in Section 148.25(d)(4): Payment to a Qualifying Hospital
- 1) For which the Department had no inpatient base period paid claims data, shall be the product of the following:
- A) \$604.00; and
- B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).
- ~~The total annual adjustment amount to a qualified hospital shall be the sum of the hospital-specific inpatient cost coverage adjustment amount, as described in subsection (b)(3)(H) of this Section, plus the hospital-specific outpatient cost coverage adjustment amount, as described in subsection (b)(3)(I) of this Section.~~
- 2) For which the Department had inpatient base period paid claims data, shall be the product of the following: The total annual adjustment amount shall be paid to the hospital during the Rural Adjustment Payment rate period, as described in subsection (d)(7) of this Section, on at least a quarterly basis.
- A) The hospital-specific rate, as determined in subsection (d).
- B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

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- d) The hospital-specific rate is calculated as the sum of:
- 1) The per diem rate for long term acute care services in effect on July 1, 2011.
 - 2) The quotient, rounded to the nearest hundredth, of the hospital's allocated static payments divided by the hospital's covered days in the inpatient base period paid claims data.
- e) ~~d~~) Definitions
- "Allocated static payments" means the adjustment payments made to the hospital pursuant to Sections 148.105, 148.115, 148.126, 148.295, 148.296 and 148.298 during SFY 2011 pursuant to the methodologies outlined in rule as of February 21, 2014 (see <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>), as determined by the Department, allocated to long-term acute care services based on the ratio of long-term acute care claim charges, excluding psychiatric claim charges, to total inpatient claim charges determined using inpatient base period claims data.
- "Inpatient base period paid claims data" means SFY 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims.
- f) Long Term Acute Care Supplemental Per Diem Rates.
- 1) The 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], shall be the amount in effect as of October 1, 2010.
 - 2) No new hospital may qualify under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act after June 14, 2012.
 - 1) "Hospital cost to charge ratio" means the quotient of the fraction, the numerator of which is the cost as reported on Form CMS 2552, worksheet C, Part 1, column 1, row 101, the denominator of which is the charges as reported on Form CMS 2552, worksheet C, Part 1, column 8, row 101. The base year for State Fiscal Year (SFY) 2003 shall be the hospital's

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~~fiscal year 1999 Medicare cost report, and, for SFY 2004, the hospital's fiscal year 2000 cost report shall be utilized. The base year for any SFY shall be determined in this manner.~~

- 2) ~~"Inpatient payments" shall mean all payments associated with total days provided, as described in subsection (d)(4) of this Section, and all quarterly adjustment payments paid, as described throughout Part 148, excluding the Rural Adjustment Payments described in this Section.~~
- 3) ~~"Outpatient payments" shall mean all payments associated with total outpatient services provided, as described in subsection (d)(5) of this Section, and all quarterly adjustment payments paid, as described in this Part, excluding the Rural Adjustment Payments described in this Section.~~
- 4) ~~"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 Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.~~
- 5) ~~"Total outpatient services" means the number of outpatient services provided during the Rural Adjustment Payment base year to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for services occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.~~
- 6) ~~"Rural Adjustment Payment base year" means, for the Rural Adjustment Payment rate period beginning October 1, 2002, SFY 2001; for the Rural Adjustment Payment rate period beginning July 1, 2003, SFY 2002. The Rural Adjustment Payment base year for subsequent rate periods shall be determined in this manner.~~

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- 7) ~~"Rural Adjustment Payment rate period" means, beginning October 1, 2002, the nine month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12 month period beginning July 1 of that year and ending June 30 of the following year.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.116 Reimbursement Methodologies for Children's Specialty Hospitals

Effective for dates of outpatient services on or after July 1, 2014 and inpatient discharges on or after July 1, 2014:

- a) Inpatient general acute care services provided by a Children's Specialty Hospital located in Illinois, as defined in Section 148.25(i) and excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b), shall, per day of covered inpatient care, be reimbursed as follows:
- 1) For a hospital that would not have met the definition of a children's specialty hospital as of July 1, 2013, \$1,400.00 per day.
 - 2) For a hospital that would have met the definition of a children's specialty hospital as of July 1, 2013, a rate equal to the per diem base rate in place on July 1, 2013, multiplied by a factor of 1.37.
 - 3) The total payment for inpatient stay will equal the sum of:
 - A) The payment determined in this subsection; and
 - B) Any applicable adjustments to payment specified in Section 148.290.
- b) For Children's specialty hospitals defined in 148.25(i), outpatient and clinic services shall be reimbursed in accordance with Section 148.140.
- c) Access to Outpatient Care

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- 1) To ensure access to outpatient care and maintain stability for children's specialty hospitals located in Illinois, the Department shall make annual outpatient transitional payments equal to the product of:
 - A) The amount of static payments made to the hospital in State fiscal year 2011 in accordance with 89 Ill. Adm. Code 148.126, 148.295, 148.296, 148.297 and 148.298 pursuant to the methodologies outlined in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>; and
 - B) .8695.
- 2) The annual amount determined in this subsection shall be paid in monthly installments equal to 1/12 of the annual amount.
- d) The reimbursement methodologies in this Section shall be re-determined prior to July 1, 2018 if implementation of reform to hospital non-institutional service reimbursement occurs. In the absence of reform to hospital non-institutional service reimbursement, the reimbursement methodologies in this Section shall be re-determined to be effective on or after July 1, 2018.
- e) For cost reporting hospitals located outside of Illinois that meet the definition of a Children's specialty hospitals as defined in Section 148.25(i) as of 6/30/14, for inpatient general acute care and rehabilitation services, the hospital shall have a per diem amount equal to the rate in place with the Department as of June 30, 2014. The total payment for inpatient stay will equal the sum of the payment determined in this Subsection and any applicable adjustments to payments specified in Section 148.290.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.117 Outpatient Assistance Adjustment Payments

Effective for dates of service on or after July 1, 2014, except when specifically designated otherwise in this Section:

- 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):

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- ~~1)~~ ~~A 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 70% and has provided greater than 10,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.~~
- 1)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.~~
- 2)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.
- 3)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.
- 4)6) A hospital that has an MIUR of greater than 70% and an emergency care percentage greater than 90%.
- 5)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

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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 8,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

~~6)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.

~~7)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.

~~8)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.

~~9)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.

~~10)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.

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~~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.~~

~~11)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.~~

~~1)2) For hospitals qualifying under subsection (a)(12), the rate is \$850.00 for dates of service through February 28, 2014. For dates of service on March 1, 2014 through June 30, 2014, the rate is \$1,523.00. For dates of service on or after July 1, 2014, the rate is \$0.00.~~

~~3) For hospitals qualifying under subsection (a)(3), the rate is \$425.00.~~

~~2)4) For hospitals qualifying under subsection (a)(24), the rate is \$290.00 for dates of service on or after July 1, 2014 \$665.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$375.00.~~

~~3)5) For hospitals qualifying under subsection (a)(35), the rate is \$250.00 for dates of service on or after July 1, 2014.~~

~~4)6) For hospitals qualifying under subsection (a)(46), the rate is \$336.25 for dates of service on or after July 1, 2014.~~

~~5)7) For hospitals qualifying under subsection (a)(57), the rate is \$110.00 for dates of service on or after July 1, 2014.~~

~~6)8) For hospitals qualifying under subsection (a)(68), the rate is \$200.00 for dates of service on or after July 1, 2014.~~

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- ~~7)9)~~ For hospitals qualifying under subsection (a)(~~79~~), the rate is ~~\$128.50 through June 30, 2010.~~ \$247.50 for dates of service on or after July 1, 2014. ~~For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by \$74.00, to \$202.50. For dates of service on or after July 1, 2012 through December 31, 2014, the rate is \$247.50. For dates of service on or after January 1, 2015, the rate is \$48.50.~~
- ~~8)10)~~ For hospitals qualifying under subsection (a)(~~810~~), the rate is ~~\$135.00~~ \$205.00 for dates of service on or after July 1, 2014. ~~For dates of service on or after July 1, 2010 through December 31, 2014, 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.~~
- ~~9)11)~~ For hospitals qualifying under subsection (a)(~~911~~), the rate is \$65.00 for dates of service on or after July 1, 2014.
- ~~10)12)~~ For hospitals qualifying under subsection (a)(~~1012~~), the rate is \$90.00 for dates of service on or after July 1, 2014.
- ~~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.
- ~~11)14)~~ For hospitals qualifying under subsection (a)(~~1114~~), the rate is \$47.00 for dates of service on or after July 1, 2010 ~~through December 31, 2014.~~ ~~For dates of service on or after January 1, 2015, 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

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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.
- 2) "General acute care hospital" is a hospital that does not meet the definition of a hospital contained in Section 148.25(a) and (d)~~89-III. Adm. Code 149.50(e)~~.
- 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.

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- 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 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 38 Ill. Reg. 15165, effective July 2, 2014)

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Section 148.120 Disproportionate Share Hospital (DSH) AdjustmentsEffective for dates of service on or after July 1, 2014:

~~Disproportionate Share Hospital (DSH) adjustments for inpatient services provided prior to October 1, 2003, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 2003, and each October 1, thereafter unless otherwise noted.~~

- a) Qualified Disproportionate Share Hospitals (DSH). ~~The~~For inpatient services provided on or after October 1, 2003, the Department shall make adjustment payments to hospitals that are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:
- 1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in subsection (i)(4) ~~of this Section~~, is at least one standard deviation above the mean Medicaid utilization rate, as defined in subsection (i)(3) ~~of this Section~~.
 - 2) The hospital's low income utilization rate, as defined in subsection (i)(6), exceeds 25 per centum. ~~For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government funded care) must be added.~~
- b) In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform nonemergency obstetric procedures at the hospital. This requirement does not

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apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in Section 148.25(d), 89 Ill. Adm. Code 149.50(e)(1) through (e)(4), must submit a statement to that effect.

- c) In making the determination described in subsection (a)(1) ~~of this Section~~, the Department shall utilize:
- 1) Hospital Cost Reports
 - A) The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in subsection (i)(4) ~~of this Section~~, ~~that which~~ have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.
 - B) In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsection (a)(1) ~~of this Section~~. Submittal of a corrected cost report in support of subsection (a)(1) ~~of this Section~~ must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's MIUR as described in subsection (i)(4) ~~of this Section~~.
 - C) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (i)(4), that have been derived from unaudited cost reports are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsection (c)(1)(B), hospitals shall have

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~~the opportunity to submit corrected information prior to the Department's final DSH determination. In the event of extensions to the Medicare cost report filing process, those hospitals that do not have an audited or unaudited base year Medicaid cost report on file with the Department by the 30th of April preceding the DSH determination are required to complete and submit to the Department a Hospital Day Statistics Collection (HDSC) form. On the form, hospitals must provide total Medicaid days and total hospital days for the hospital's base fiscal year. The HDSC form must be submitted to the Department by the April 30th preceding the DSH determination.~~

- ~~i) If the Medicare deadline for submitting base fiscal year cost reports falls within the month of June preceding the DSH determination, hospitals, regardless of their base fiscal year end date, will have until the first day of August preceding the DSH determination to submit changes to their Medicaid cost reports for inclusion in the final DSH calculations. In this case, the HDSC form will not be used as a data source for the final rate year DSH determination.~~
- ~~ii) If the Medicare deadline for submitting base fiscal year cost reports is extended beyond the month of June preceding the DSH determination, the HDSC form will be used in the final DSH determination for all hospitals that do not have an audited or unaudited Medicaid cost report on file with the Department. Hospitals will have until the first day of July to submit any adjustments to the information provided on the HDSC form sent to the Department on April 30.~~

- ~~D) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (i)(4) of this Section, which have been derived from unaudited cost reports or the HDSC form, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsections (e)(1)(B) and (e)(1)(C)(ii) of this Section, hospitals shall have the opportunity to submit corrected information prior to the~~

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~~Department's final DSH determination-~~

~~D)E)~~ In the event a subsequent final audited cost report reflects an MIUR, as described in subsection (i)(4)-~~of this Section~~, ~~that~~which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report or the HDSC form utilized for the DSH determination, the Department shall recalculate the MIUR based upon the final audited cost report, and recoup any overpayments made if the percentage change in the DSH payment rate is greater than five percent.

- 2) Days Not Available from Cost Report
 Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid ~~managed care entity (MCE)~~Health Maintenance Organization (HMO) days, hospital residing long term care days, and Medicaid days for alcohol and substance abuse ~~sub-acute~~rehabilitative care under category of service 035. To obtain Medicaid utilization levels in these instances, the Department shall utilize:
- A) Medicare/Medicaid Crossover Claims. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year.
- i) ~~For DSH determination years on or after October 1, 1996, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Provider logs as described in the following subsection (e)(3)(A)(ii) will not be used in the determination process for DSH determination years on or after October 1, 1996.~~
- ii) ~~For DSH determination years prior to October 1, 1996, hospitals may submit additional information to document Medicare/Medicaid crossover days that were not billed to the Department due to a determination that the Department~~

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~~had no liability for deductible or coinsurance amounts. That information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. That log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.~~

- B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.
- C) ~~MCEHMO~~ days. The Department will utilize the Department's ~~MCEHMO~~ claims data available to the Department as of the last day of June preceding the DSH determination year, or specific claim information from each ~~MCEHMO~~, for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an ~~MCEHMO~~.
- D) Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.
- E) Alcohol and Substance Abuse Days. The Department will utilize

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its paid claims data under category of service 35 available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided for alcohol and substance abuse rehabilitative care.

- d) Hospitals may apply for DSH status under subsection (a)(2) ~~of this Section~~ by submitting an audited certified financial statement, for the hospital's base fiscal year, to the Department ~~of Human Services or the Department of Public Aid~~. The statements must contain the following breakdown of information prior to submittal to the Department for consideration:
- 1) Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.
 - 2) Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.
 - 3) Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, ~~except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance~~), for the hospital's base fiscal year.
 - 4) Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.
- e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the state in which they are located based upon the ~~federal~~ Federal definition of a DSH hospital ~~(42 USC 1396-4(b)(1), as defined in section 1923(b)(1) of the Social Security Act,~~ may qualify for DSH hospital adjustments under this Section. For purposes of determining the MIUR, as described in subsection (i)(4) ~~of this Section~~ and as required in the federal definition (42 USC 1396r-4(b)(1), section 1923(b)(1) of the Social Security Act, out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not

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qualify by the MIUR from their state may submit an audited certified financial statement as described in subsection (d) ~~of this Section~~. Payments to out-of-state hospitals will be allocated using the same method as described in subsection (g) ~~of this Section~~.

- f) Time Limitation Requirements for Additional Information.
- 1) ~~The Except as provided in subsection (c)(1)(C), the~~ information required in subsections (a), (c), (d) and (e) ~~of this Section~~ must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of ~~the such~~ information for the determination of DSH qualification. Information required in subsections (a), (c), (d) and (e) ~~that of this Section~~ which is not received or post marked in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.
 - 2) The information required in subsection (b) ~~of this Section~~ must be submitted after receipt of notification from the Department. Information required in this Section that is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.
- g) Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by subsection (a) ~~of this Section~~ shall be calculated annually as follows:
- 1) Five Million Dollar Fund Adjustment for hospitals defined in Section 148.25(b)(1), with the exception of any Illinois hospital that is owned or operated by the State or a unit of local government.
 - A) Hospitals qualifying as DSH hospitals under subsection (a)(1) or (a)(2) ~~of this Section~~ will receive an add-on payment to their inpatient rate.
 - B) The distribution method for the add-on payment described in subsection (g)(1) ~~of this Section~~ is based upon a fund of \$5 million. All hospitals qualifying under subsection (g)(1)(A) ~~of this Section~~ will receive a \$5 per day add-on to their current rate. The

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total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by \$5. The total dollar amount of this calculation is then subtracted from the \$5 million fund.

- C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) ~~of this Section~~ in proportion to the percentage by which the hospital's MIUR exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate, as described in subsection (i)(3) ~~of this Section~~. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the \$5 million pool of money available after the \$5 per day base add-on has been subtracted.
- D) The total dollar amount calculated for each qualifying hospital under subsection (g)(1)(C) ~~of this Section~~, plus the initial \$5 per day add-on amount calculated for each qualifying hospital under subsection (g)(1)(B) ~~of this Section~~, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day add-on value. Hospitals qualifying under subsection (a)(2) ~~of this Section~~ will receive the minimum adjustment of \$5 per inpatient day. The adjustments calculated under this subsection (g)(1) are subject to the limitations described in subsection (h) ~~of this Section~~. The adjustments calculated under subsection (g) ~~of this Section~~ shall be paid on a per diem basis and shall be applied to each covered day of care provided.

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- 2) Department of Human Services (DHS) State-Operated Facility Adjustment for Hospitals Defined in Section ~~148.25(a)(3)~~~~148.25(b)(6)~~. ~~DHS~~~~Department of Human Services~~ State-operated facilities qualifying under subsection (a)(2) of this Section shall receive an adjustment for inpatient services provided on or after March 1, 1995. Effective October 1, 2000, the adjustment payment shall be calculated as follows:
- A) The amount of the adjustment is based on a State DSH Pool. The State DSH Pool amount shall be the ~~lesser of the~~ federal DSH allotment for mental health facilities as determined in section 1923(h) of the Social Security Act, minus the estimated DSH payments to such facilities that are not operated by the State; ~~or the result of subtracting the estimated DSH payment adjustments made under subsection (g)(1) of this Section and Section 148.170(f)(2) from the aggregate DSH payment allotment as provided for in section 1923(f) of the Social Security Act.~~
- B) The State DSH Pool amount is then allocated to hospitals defined in Section ~~148.25(a)(3)~~~~148.25(b)(6)~~ that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of uncompensated care costs, from the most recent final cost report, to the sum of all qualifying hospitals' uncompensated care costs.
- C) The adjustment calculated in subsection (g)(2)(B) ~~of this Section~~ shall meet the limitation described in subsection (h)(4) ~~of this Section~~.
- D) The adjustment calculated pursuant to subsection (g)(2)(B) ~~of this Section~~, for each hospital defined in Section ~~148.25(a)(3)~~~~148.25(b)(6)~~ that qualifies for DSH adjustments, is then divided by four to arrive at a quarterly adjustment. This amount is subject to the limitations described in subsection (h) ~~of this Section~~. The adjustment described in this subsection (g)(2)(D) shall be paid on a quarterly basis.
- 3) Assistance for Certain Public Hospitals

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- A) The Department may make an annual payment adjustment to qualifying hospitals in the DSH determination year. A qualifying hospital is a public hospital as defined in section 701(d) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554).
- B) Hospitals qualifying shall receive an annual payment adjustment that is equal to:
- i) A rate amount equal to the amount specified in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, section 701(d)(3)(B) for the DSH determination year;
 - ii) Divided first by Illinois' Federal Medical Assistance Percentage; ~~and~~
 - iii) Divided secondly by the sum of the qualified hospitals' total Medicaid inpatient days, as defined in subsection (i)(4) ~~of this Section~~; and
 - iv) Multiplied by each qualified hospital's Medicaid inpatient days as defined in subsection (i)(4) ~~of this Section~~.
- C) The annual payment adjustment calculated under this subsection (g)(3), for each qualified hospital, will be divided by four and paid on a quarterly basis.
- D) Payment adjustments under this subsection (g)(3) shall be made without regard to subsections (h)(3) and (4) of this Section, 42 CFR 447.272, or any standards promulgated by the Department of Health and Human Services pursuant to section 701(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.
- E) In order to qualify for assistance payments under this subsection (g)(3), with regard to this payment adjustment, there must be in force an executed intergovernmental agreement between the

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authorized governmental body of the qualifying hospital and the Department.

- 4) Disproportionate Share Payments for Certain Government-Owned or -Operated Hospitals
 - A) The following classes of government-owned or -operated Illinois hospitals shall, subject to the limitations set forth in subsection (h) ~~of this Section~~, be eligible for the Disproportionate Share Hospital Adjustment payment:
 - i) Hospitals defined in Section ~~148.25(a)+48.25(b)(1)(A)~~.
 - ii) Hospitals owned or operated by a unit of local government that is located within Illinois and is not a hospital defined in subsection ~~(i)(g)(4)(A)(i) of this Section~~.
 - iii) ~~Hospital defined in Section 148.25(b)(1)(B)~~.
 - B) The annual amount of the payment shall be the amount computed for the hospital pursuant to federal limitations.
 - C) The annual amount shall be paid to the hospital in monthly installments. ~~The portion of the annual amount not paid pending federal approval of payments shall, upon that approval, be paid in a single lump sum payment. Except as indicated in this subsection (g)(4)(C), the annual amount shall be paid to the hospital in 12 equal installments and paid monthly.~~
- h) DSH Adjustment Limitations:
 - 1) Hospitals that qualify for DSH adjustments under this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues provision of nonemergency obstetrical care. The provisions of this subsection (h)(1) shall not apply to those hospitals described in ~~Section 148.25(d)89 Ill. Adm. Code 149.50(e)(1) through (e)(4)~~ or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987. In this instance, the adjustments

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calculated under subsection (g)(1) shall cease to be effective on the date that the hospital discontinued the provision of such nonemergency obstetrical care.

- 2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for DSH payment adjustments based upon the requirements of this Section.
- 3) DSH Payment Adjustment. ~~If in accordance with Public Law 102-234, if~~ the aggregate DSH payment adjustments calculated under this Section do not meet the State's final DSH Allotment as determined by the federal Centers for Medicare and Medicaid Services, DSH payment adjustments calculated under this Section shall be adjusted to meet the State DSH Allotment. Subject to any limitation, disproportionate share payments will be made to qualifying hospitals in the following order:
 - A) ~~Hospitals defined in Section 148.25(a)(3) Psychiatric hospitals operated by the Illinois Department of Human Services~~ – the annual amount shall be credited quarterly via certification of public expenditure.
 - B) Hospitals defined in Section ~~148.25(a)(2)148.25(b)(1)(B)~~.
 - C) Hospitals ~~defined in subsection (g)(4)(A)(ii) of this Section. owned and operated by a unit of local government that is not a hospital defined in Section 148.25(b)(1)(A)~~.
 - D) Hospitals that are not owned or operated by a unit of government – the annual amount shall be paid on each inpatient claim.
 - E) Hospitals defined in Section ~~148.25(a)(1)148.25(b)(1)(A)~~.

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- 4) Omnibus Budget Reconciliation Act of 1993 (OBRA'93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospitals' disproportionate share payments shall be made if the sum of estimated Medicaid payments (inpatient, outpatient, and disproportionate share) to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. Federal upper payment limit requirements (42 CFR 447.272) shall be considered when calculating the OBRA'93 adjustments. The adjustments shall reduce disproportionate share spending until the costs and spending (described in this subsection (h)(4)) are equal or until the disproportionate share payments are reduced to zero. In this calculation, persons without insurance costs do not include contractual allowances. Hospitals qualifying for DSH payment adjustments must submit the information required in Section 148.150.
- 5) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's MIUR, as defined in subsection (i)(4) of this Section, is less than one percent.
 - i) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:
 - 1) "Base fiscal year" means ~~, for example, the hospital's fiscal year ending in the calendar year 22 months before the beginning of the 2001 for the October 1, 2003 DSH determination year, the hospital's fiscal year ending in 2002 for the October 1, 2004 DSH determination year, etc.~~
 - 2) "DSH determination year" means the 12-month period beginning on October 1 of the year and ending September 30 of the following year.
 - 3) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the ~~federal~~ Federal Social Security Act (42 USC 1396a et seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. ~~Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General~~

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~~Assistance) but does include the types of days described in subsections (c)(1) and (c)(2) of this Section.~~ In this subsection (i)(3), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

- 4) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12 month period to patients who, for such days, were eligible for Medicaid under Title XIX of the ~~federal~~Federal Social Security Act (42 USC 1396a et seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. ~~Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) but does include the types of days described in subsections (c)(1) and (c)(2) of this Section.~~ In this subsection (i)(4), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.
- 5) "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.
- 6) "Low income utilization rate" means a fraction, expressed as a percentage that is the sum of the amount resulting from the calculations in subsection (i)(6)(A) plus (i)(6)(B):
- A) The fraction (expressed as a percentage) –
- i) the numerator of which is the sum of the total revenues paid the hospital for patient services under Medicaid State plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and the amount of the cash subsidies for patient services received directly from State and local governments, and

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- ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and
- B) The fraction (expressed as a percentage) –
 - i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in subsection (6)(A)(i); and
 - ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.122 Medicaid Percentage Adjustments

Effective for dates of service on or after July 1, 2014, the~~The~~ Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1 of each year~~October 1, 2003, and each October 1 thereafter~~ unless otherwise noted.

- a) Qualified Medicaid Percentage Hospitals. ~~The~~~~For inpatient services provided on or after October 1, 2003, the~~ Department shall make adjustment payments to hospitals that are deemed as a Medicaid percentage hospital by the Department. A hospital, except those that are owned or operated by a unit of government, may qualify for a Medicaid Percentage Adjustment in one of the following ways:
 - 1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section 148.120(i)(4), is at least one-half standard deviation above the mean Medicaid utilization rate, as defined in Section 148.120(i)(3).
 - 2) The hospital's low income utilization rate, as defined in Section 148.120(i)(6), exceeds 25 per centum. ~~For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government funded care, must be counted as a percentage of all net~~

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~~patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government-funded care) must be added.~~

- 3) Illinois hospitals that, on July 1, 1991, had an MIUR, as defined in Section 148.120(i)(4), that was at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(i)(3), and that were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CFR 5 (1989)).
 - 4) Illinois hospitals that meet the following criteria:
 - A) Have an MIUR, as defined in Section 148.120(i)(4), that is at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(i)(3), ~~and~~
 - B) Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (g)(3) ~~of this Section~~, that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (g)(2) ~~of this Section~~.
 - 5) Any children's hospital, as defined in Section 148.25(d)(3)89 Ill. Adm. Code 149.50(c)(3).
 - 6) Out of state hospitals meeting the criteria in Section 148.120(e).
- b) In making the determination described in subsections (a)(1) and (a)(4)(A) ~~of this Section~~, the Department shall utilize the data described in Section 148.120(c) and received in compliance with Section 148.120(f).
 - c) Hospitals ~~that may apply to become a~~ qualified as a Medicaid Percentage Adjustment hospital under subsection (a)(2) for the Medicaid percentage determination year beginning October 1, 2013 may apply annually to become qualified under subsection (a)(2) of this Section by submitting audited certified

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financial statements as described in Section 148.120(d) and received in compliance with Section 148.120(f).

- d) Medicaid Percentage Adjustments. The adjustment payments required by subsection (a) of this Section for qualified hospitals shall be calculated annually as follows for hospitals defined in Section 148.25(b)(1), excluding hospitals defined in Section ~~148.25(a), 148.25(b)(1)(A) and (b)(1)(B)~~.
- 1) The payment adjustment shall be calculated based upon the hospital's MIUR, as defined in Section 148.120(i)(4), and subject to subsection (e) of this Section, as follows:
 - A) Hospitals with an MIUR below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$25;
 - B) Hospitals with an MIUR that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$25 plus \$1 for each one percent that the hospital's MIUR exceeds the mean Medicaid inpatient utilization rate;
 - C) Hospitals with an MIUR that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$40 plus \$7 for each one percent that the hospital's MIUR exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and
 - D) Hospitals with an MIUR that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$90 plus \$2 for each one percent that the hospital's MIUR exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.
 - 2) The Medicaid Percentage Adjustment payment, calculated in accordance with this subsection (d), to a hospital, ~~other than a hospital and/or hospitals~~

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~~organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B);~~ shall not exceed \$155 per day for a children's hospital, as defined in Section 148.25(d)(3)89 Ill. Adm. Code 149.50(e)(3), and shall not exceed \$215 per day for all other hospitals.

- 3) The amount calculated pursuant to subsections (d)(1) through (d)(2) of this Section shall be adjusted by the aggregate annual increase in the national hospital market basket price proxies (DRI) hospital cost index from DSH determination year 1993, as defined in Section 148.120(i)(2), through DSH determination year 2003; and annually thereafter, by a percentage equal to the lesser of:
 - A) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or
 - B) The percentage increase in the Statewide average hospital payment rate, ~~as described in subsection (g)(5) of this Section,~~ over the previous year's Statewide average hospital payment rate.
- 4) The amount calculated pursuant to subsections (d)(1) through (d)(3) ~~of this Section, as adjusted pursuant to subsection (e) of this Section,~~ shall be the inpatient payment adjustment in dollars for the applicable Medicaid percentage determination year. The adjustments calculated under subsections (d)(1) through (d)(3) ~~of this Section~~ shall be paid on a per diem basis and shall be applied to each covered day of care provided.
- e) Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in Section 148.25(d)(3)89 Ill. Adm. Code 149.50(e)(3), the payment adjustment calculated under subsection (d)(1) ~~of this Section~~ shall be multiplied by 2.0.
- f) Medicaid Percentage Adjustment Limitations.
 - 1) In addition, to be deemed a Medicaid Percentage Adjustment hospital, a hospital must provide to the Department, in writing, the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that

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is, an area outside of a Metropolitan Statistical Area, as defined by the federal Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform non-emergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age, or does not offer non-emergency obstetric services as of December 22, 1987. Hospitals that do not offer non-emergency obstetrics to the general public, with the exception of those hospitals described in ~~Section 148.25(d)89 Ill. Adm. Code 149.50(e)(1) through (e)(4)~~, must submit a statement to that effect.

- 2) Hospitals that qualify for Medicaid Percentage Adjustments under this Section shall not be eligible for the total Medicaid Percentage Adjustment if, during the Medicaid Percentage Adjustment determination year, the hospital discontinues provision of non-emergency obstetrical care. The provisions of this subsection (f)(2) shall not apply to those hospitals described in ~~Section 148.25(d)89 Ill. Adm. Code 149.50(e)(1) through (e)(4)~~ or those hospitals that have not offered non-emergency obstetrical services as of December 22, 1987. In this instance, the adjustments calculated under subsection (d) shall cease to be effective on the date that the hospital discontinued the provision of ~~such~~ non-emergency obstetrical care.
- 3) Appeals based upon a hospital's ineligibility for Medicaid Percentage payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), ~~that which~~ result in a change in a hospital's eligibility for Medicaid Percentage payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the Medicaid Percentage status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for Medicaid Percentage payment adjustments based upon the requirements of this Section.
- 4) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for Medicaid percentage payment adjustments under this Section shall not be eligible for Medicaid percentage payment adjustments if the hospital's MIUR, as defined in Section 148.120(i)(4), is less than one percent.

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- g) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of Inpatient Payment Adjustments are as follows:
- 1) "Medicaid Percentage determination year" ~~has the same meaning as the DSH determination year defined in Section 148.120(i)(2) means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.~~
 - 2) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g)(4) ~~of this Section~~, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the ~~federal~~ Federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid inpatient days, as defined in subsection (g)(6) ~~of this Section~~, for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the ~~Medicaid percentage~~ DSH determination year and contained within the Department's paid claims data base.
 - 3) "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g)(4) ~~of this Section~~, provided by a Medicaid-participating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (g)(6) ~~of this Section~~, provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base.
 - 4) "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days that were subsequently adjudicated by the Department through the

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last day of June preceding the Medicaid Percentage Adjustment determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act (~~specifically excluding Medicare/Medicaid crossover claims~~), with a Diagnosis Related Grouping (DRG) of ~~370 through 375, and specifically excludes Medicare/Medicaid crossover claims.~~

A) 370 through 375 for claims adjudicated before July 1, 2014; or

B) 540, 541, 542 or 560 for claims adjudicated on or after July 1, 2014.

- ~~5) "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).~~
- ~~5)6) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (g)(2) and (g)(3) of this Section, means hospital inpatient days, excluding days for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.~~
- 7) "Medicaid obstetrical inpatient utilization rate base year" means, for example, fiscal year 2002 for the October 1, 2003, Medicaid Percentage Adjustment determination year; fiscal year 2003 for the October 1, 2004, Medicaid Percentage Adjustment determination year; etc.
- 8) "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.126 Safety Net Adjustment Payments

Effective for dates of service on or after July 1, 2014, except when specifically designated otherwise in this Section:

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- 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).~~
 - 24) The hospital is, as of October 1, 2001, a rural hospital, as described in Section 148.446(a)(1)~~148.25(g)(3)~~, that meets all of the following criteria:
 - 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).~~
 - 36) 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.

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C) Provided greater than 15,000 total days in the safety net hospital base year.

47) The hospital meets all of the following criteria:

A) Does not already qualify under subsections (a)(1) through (a)~~(3)(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.~~

~~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.~~

59) The hospital meets all of the following criteria in the safety net base year:

A) Is a psychiatric hospital, as described in Section 148.25(d)(1)89-III-Adm. Code 149.50(e)(1).

B) Has licensed beds greater than 120.

C) Has an average length of stay less than 10~~ten~~ days.

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- ~~6)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)(~~59~~) 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.
- ~~7)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)(~~6~~)(~~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.
- ~~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:~~

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- 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.~~
- ~~8)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)~~(7)(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 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(e), 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.~~
- ~~9)17)~~ The hospital meets all of the following criteria in the safety net base year:

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- A) Does not already qualify under subsections (a)(1) through (a)(~~8~~)(~~16~~) of this Section.
- B) Is located outside [Health Service Area \(HSA\) 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.

~~10~~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%.

~~11~~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)(~~10~~)(~~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.
- 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.

~~12~~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)(~~11~~)(~~19~~) of this Section.

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- 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).~~
 - 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).~~
- e) ~~Safety Net Adjustment Rates~~
- 1) ~~For a hospital qualifying under subsection (a)(1) of this Section, the rate is~~

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~~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.~~
 - ~~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.~~

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- ~~d) 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.~~
- b) For a hospital qualifying under subsection (a)(1) 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:
- 1) Provides obstetrical care — \$210.00 for dates of service on or after July 1, 2014.
 - 2) Does not provide obstetrical care — \$90.00 for dates of service on or after July 1, 2014.
- c) For a hospital qualifying under subsection (a)(2), the rate shall be \$55.00 for dates of service on or after July 1, 2014.

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- d) For a hospital qualifying under subsection (a)(3), the rate shall be \$3.00 on or after July 1, 2014.
- e) For a hospital qualifying under subsection (a)(4), the rate shall be \$140.00 on or after July 1, 2014.
- f) For a hospital qualifying under subsection (a)(5), the rate shall be \$119.50 on or after July 1, 2014.
- g) For a hospital qualifying under subsection (a)(7), the rate shall be \$221.00 on or after July 1, 2014.
- h) For a hospital qualifying under (a)(8), the rate shall be \$100.00 on or after July 1, 2014.
- i) For a hospital qualifying under subsection (a)(9), the rate shall be \$69.00 on or after July 1, 2014. The reimbursement rate is contingent on federal approval.
- j) For a hospital qualifying under subsection (a)(10), the rate is \$56.00 for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is \$136.00. For dates of service on or after July 1, 2014, the rate is \$56.00.
- k) For a hospital qualifying under subsection (a)(11) of this Section, the rate is \$197.00 on or after July 1, 2014. 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:
- 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

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~~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—\$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~~

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~~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 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, the rate is \$210.50.~~
- 8) ~~For a hospital qualifying under subsection (a)(8) of this Section, the rate is \$124.50.~~
- 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, this rate shall be increased by \$72.00, to \$205.00. For dates of service on or after January 1, 2015, the rate is \$85.50.~~
- 1)10) For a hospital qualifying under subsection (a)~~(6)~~(10) of this Section, the rate is \$13.75. For dates of service on or after July 1, 2010 through December 31, 2014, ~~this rate shall be increased by \$25.00~~ on or after July 1, 2014, to \$38.75. For

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~~dates of service on or after January 1, 2015, 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. For dates of service on or after January 1, 2015, 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. For dates of service on or after January 1, 2015, the rate is \$16.00. This reimbursement rate is contingent on federal approval.~~
- ~~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, this rate shall be increased by \$113.00, to \$342.00. For dates of service on or after January 1, 2015, the rate is \$145.00.~~
- ~~m)19) For a hospital qualifying under subsection (a)(12)(20) of this Section, the rate is \$71.00 on or after July 1, 2014, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~
- ~~20) For a hospital qualifying under subsection (a)(21) of this Section, the rate~~

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~~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.~~

~~n)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.

~~o)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 ~~148.122(g)(3)~~ ~~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 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 ~~(m)(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 ~~DPH~~ ~~the Illinois Department of Public Health~~.

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- 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, ~~DPH~~ 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) ~~(4)(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 ~~(o)(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 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.

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- 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.

p)† 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(b)(g)(5). The payment limitation takes effect 60 days, unless extended by the Department in its sole discretion, six months after the Department begins mandatory enrollment in the geographic area.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.130 Outlier Adjustments for Exceptionally Costly Stays

- a) Outlier Adjustments. Outlier adjustments are provided for exceptionally costly stays provided by hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g) for discharges before July 1, 2014. For discharges on or after July 1, 2014, this Section shall not be

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utilized for the basis of any hospital payments.

- b) The determination of those services qualified for an outlier adjustment shall be made as follows for services provided on and after October 1, 1992, and for each subsequent rate period, as defined in Section 148.25(g)(2)(B), for hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g):
- 1) The services must have been provided on or after October 1, 1992; and
 - 2) The services must have been provided to:
 - A) Children who have not attained the age of six years by hospitals defined by the Department as DSH hospitals under Section 148.120(a); or
 - B) Infants who have not attained the age of one year by hospitals that do not meet the definition of a DSH hospital under Section 148.120(a); or
 - C) Children who have not attained the age of 19 on the date of admission for services provided on or after January 1, 2008 by a hospital devoted exclusively to the care of children as defined in 89 Ill. Adm. Code 149.50(c)(3)(A); or
 - D) Children who have not attained the age of 19 on the date of admission for services provided on or after July 1, 2009 by a Children's Hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(B).
 - 3) Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:
 - A) Total covered charges (less charges attributable to medical education) equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.
 - B) The hospital's rate for services provided on the claim shall be

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multiplied by the number of covered days on the claim.

- C) The product of subsection (b)(3)(B) shall be subtracted from the product of subsection (b)(3)(A).
 - D) The difference of subsection (b)(3)(C) shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.
 - E) Third party payments (credits) shall be applied to the final payment made on the claim.
- c) The determination of those services qualified for an outlier adjustment shall be made in accordance with 89 Ill. Adm. Code 149.105 for hospitals reimbursed on a per case basis.
- d) Definition of terms relating to outlier adjustments are as follows:
- 1) "Base fiscal year" means the hospital's fiscal year cost report most recently audited by the Department.
 - 2) "Cost to Charge Ratio" means the hospital's Medicaid total allowable cost for all care divided by the Medicaid total covered charges for all care. The Cost to Charge Ratio is derived by utilizing cost report data from the hospital's base fiscal year.
 - 3) "Mean total covered charges" means the mean total covered charges (as described in subsection (d)(5)), for services provided in the most recent state fiscal year for which complete information is available and which have been adjudicated by the Department, as follows:
 - A) For hospitals that do not meet the definition of a DSH hospital under Section 148.120(a) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of one year; and
 - B) For hospitals defined by the Department as DSH hospitals under Section 148.120(a) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to

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individuals under the age of six years.

- 4) "Rate for services provided" means the inpatient rate in effect for the type of services provided.
- 5) "Total covered charges" means the amount entered on the UB-82 or UB-92 Uniform Billing Form for revenue code 001 in column 53 (Total Charges).

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.140 Hospital Outpatient and Clinic Services

Effective for dates of service on or after July 1, 2014:

- a) Fee-For-Service Reimbursement
 - 1) Reimbursement for hospital outpatient services shall be made on a fee-for-service basis, except for:
 - A) ~~Services~~ Those services that meet the definition of the Ambulatory Procedure Listing (APL) as described in subsection (b)(1) of this Section.
 - B) End stage renal disease treatment (ESRDT) services, as described in subsection ~~(g)(e)~~ (g)(e) 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).~~
 - ~~C~~D) ~~Those services provided by a Critical Clinic Provider as described in subsection (e) of this Section.~~
 - ~~E~~) ~~Those services provided by a Freestanding Emergency Center, as described in subsection (g) of this Section.~~
 - 2) Except for the ~~services reimbursed procedures~~ services reimbursed procedures under the ~~EAPG PPS, APL groupings~~ EAPG PPS, APL groupings described in subsection (b)(1) of this Section, fee-for-service

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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) Hospitals are required to bill the Department utilizing specific service codes. 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. 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) Payments under Section 148.140(a)(4) shall cease as of June 30, 2014 for Maternal and Child Health Program Clinics. 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

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~~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) EAPG PPS Reimbursement. Reimbursement under EAPG PPS, described in subsection (c), shall be all-inclusive for all services provided by the hospital, without regard to the amount charged by a hospital. Except as provided in subsection (b)(3), no separate reimbursement will be made for ancillary services or the services of hospital personnel.

- 1) Outpatient hospital services reimbursed through the EAPG PPS shall include:
- A) Surgical services.
- B) Diagnostic and therapeutic services.
- C) Emergency department services.
- D) Observation services.
- E) Psychiatric treatment services.

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- 2) Excluded from reimbursement under the EAPG PPS are outpatient hospital services reimbursed pursuant to 59 Ill. Adm. Code 131 and 132, 77 Ill. Adm. Code 2090, and Section 148.330 of this Part.
- 3) Exceptions to All-inclusive EAPG PPS Rate
 - A) A hospital may bill separately for:
 - i) Professional services of a physician who provided direct patient care.
 - ii) Chemotherapy services provided in conjunction with radiation therapy services.
 - iii) Physical rehabilitation, occupational or speech therapy services provided in conjunction with an APG PPS reimbursed service.
 - B) For the purposes of subsection (b)(3)(A), a physician means:
 - i) A physician salaried by the hospital. Physicians salaried by the hospital do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists; no separate reimbursement will be allowed for those providers.
 - ii) A physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care.
 - iii) A group of physicians with a financial contract to provide emergency department care.
- c) EAPG PPS Payment. The reimbursement to hospitals for outpatient services provided on the same day shall be the product, rounded to the nearest hundredth, of the following:
 - 1) The EAPG weighting factor of the EAPG to which the service was assigned by the EAPG grouper.

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- 2) The EAPG conversion factor, based on the sum of:
 - A) The product, rounded to the nearest hundredth, of:
 - i) the labor-related share;
 - ii) the Medicare IPPS wage index; and
 - iii) the applicable EAPG standardized amount.
 - B) The product, rounded to the nearest hundredth, of:
 - i) non-labor share; and
 - ii) the applicable EAPG standardized amount.
 - 3) The applicable consolidation factor.
 - 4) The applicable packaging factor.
 - 5) The applicable discounting factor.
 - 6) The applicable policy adjustment factors, as defined in subsection (f), for which the service qualifies.
- d) EAPG Standardized Amount. The standardized amount established by the Department as the basis for EAPG conversion factor differs based on the provider type:
- 1) County-operated Large Public Hospital EAPG Standardized Amount. For a large public hospital, as defined in Section 148.25(a)(1), the EAPG standardized amount is determined in Section 148.160.
 - 2) University-operated Large Public Hospital EAPG Standardized Amount. For a large public hospital, as defined in Section 148.25(a)(2), the EAPG standardized amount is determined in Section 148.170.

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- 3) Critical Access Hospital EAPG Standardized Amount. For critical access hospitals, as defined in Section 148.25(g), the EAPG standardized amounts are determined separately for each critical access hospital such that simulated EAPG payments using outpatient base period paid claim data plus payments as defined in Section 148.456 net of tax costs are equal to the estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.
- 4) Acute EAPG Standardized Amount
- A) Qualifying Criteria. General acute hospitals and freestanding emergency centers as defined in 148.25(e) excluding providers in subsections (d)(1) through (d)(3), freestanding psychiatric hospitals, psychiatric distinct part units, freestanding rehabilitation hospitals, and rehabilitation distinct part units.
- B) The acute EAPG standardized amount is based on a single statewide amount determined such that:
- i) Simulated EAPG payments, without SMART Act reductions or policy adjustments defined in subsection (f), using general acute hospital outpatient base period paid claims data, result in approximately a \$75 million increase compared to the amount derived in subsection (d)(4)(B)(ii).
- ii) The sum of general acute hospital base period paid claims data reported payments and allocated outpatient static payments.
- 5) Psychiatric EAPG Standardized Amount
- A) Qualifying Criteria. Freestanding psychiatric hospitals and psychiatric distinct part units.
- B) The psychiatric EAPG standardized amount is based on a single statewide amount, determined such that:

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- i) Simulated EAPG payments, without policy adjustments defined in subsection (f), using freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data, results in payments approximately equal to the amount derived in subsection (d)(5)(B)(ii).
 - ii) The sum of freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.
 - 6) Rehabilitation EAPG Standardized Amount
 - A) Qualifying Criteria. Freestanding rehabilitation hospitals and rehabilitation distinct part units.
 - B) The rehabilitation EAPG standardized amount is based on a single statewide amount, determined such that:
 - i) Simulated EAPG payments, without SMART Act reductions or policy adjustments defined in subsection (f), using freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data, results in payments approximately equal to the annual derived in subsection (d)(6)(B)(ii).
 - ii) The sum of freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.
 - 7) Ambulatory Surgical Treatment Center (ASTC) EAPG Standardized Amount. For ASTC's, as defined in 89 Ill. Adm. Code 146.105, the EAPG standardized amount is determined such that simulated EAPG payments using outpatient base period paid claims data are equal to reported payments of outpatient base period paid claims data as contained in the Department's claims data warehouse.

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- 8) Out-of-state non-cost reporting hospital EAPG standardized amount. For non-cost reporting hospitals, the EAPG standardized amount is \$362.32.
- e) Discounting factor. The applicable discounting factor is based on the discounting flags designated by the EAPG grouper under default EAPG settings:
- 1) The discounting factor will be 1.0000, if the following criteria are met:
- A) The service has not been designated with a Bilateral Procedure Discounting flag, Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or
- B) The service has not been designated with a Bilateral Procedure Discounting flag and has been designated with a Multiple Procedure Discounting flag by the EAPG grouper under default EAPG settings and the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.
- 2) The discounting factor will be 0.5000 if the following criteria are met:
- A) The service has been designated with a Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day; and
- B) The service has not been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings.
- 3) The discounting factor will be 0.7500 if the following criteria are met:

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- A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and
 - B) The service has been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.
- 4) The discounting factor will be 1.5000 if the following criteria are met:
 - A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and
 - B) The service has not been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or if the Multiple Procedure Discounting flag is present, the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.
- f) Policy Adjustments. Claims for services by providers that meet certain criteria shall qualify for further adjustments to payment. If a claim qualifies for more than one policy adjustment, then the EAPG PPS payment will be multiplied by both factors.
 - 1) Safety Net Hospital Qualifying Criteria
 - A) The service is described in subsection (b)(1), excluding Medicare crossover claims.
 - B) The hospital is a Safety Net hospital, as defined in Section 5-5e.1 of the Illinois Public Aid Code that is not:

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- i) A critical access hospital, as defined in Section 148.25(g).
 - ii) A large public hospital, as defined in Section 148.25(a).
 - C) Policy adjustment factor effective SFY 2015 and 2016 is 1.3218.
 - 2) High Outpatient Volume Hospital Qualifying Criteria
 - A) The service is described in subsection (b)(1), excluding Medicare crossover claims.
 - B) The hospital is a High Outpatient Volume hospital, as defined in subsection (f)(2)(C) that is not:
 - i) A critical access hospital, as defined in Section 148.25(g).
 - ii) A large public hospital, as defined in Section 148.25(a).
 - iii) A Safety Net hospital, as defined in Section 5-5e.1 of the Illinois Public Aid Code.
 - C) A High Outpatient Volume hospital for which the high outpatient volume is at least:
 - i) 1.5 standard deviations above the mean regional high outpatient volume; or
 - ii) 1.5 standard deviations above the mean statewide high outpatient volume.
 - D) Policy adjustment factor effective SFY 2015 and 2016 is 1.3218.
 - 3) Crossover Adjustment Factor
 - A) Acute EAPG standardized amounts, as defined in subsection (d)(4), shall be reduced by a Crossover Adjustment factor such that:

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- 3) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.
- h) Updates to EAPG PPS Reimbursement. The Department may annually review the components listed in subsection (c) and make adjustments as needed. Grouper shall be updated at least triennially and no more frequently than annually.
- i) Definitions

"Aggregate ancillary cost-to-charge ratio" means the ratio of each hospital's total ancillary costs and charges reported in the Medicare cost report, excluding special purpose cost centers and the ambulance cost center, for the cost reporting period matching the outpatient base period claims data. Aggregate ancillary cost-to-charge ratios applied to SFY 2011 outpatient base period claims data will be based on fiscal year ending 2011 Medicare cost report data.

"Consolidation factor" means a factor of 0 percent applicable for services designated with a Same Procedure Consolidation flag or Clinical Procedure Consolidation flag by the EAPG grouper under default EAPG settings.

"Default EAPG settings" means the default EAPG grouper options in 3M's Core Grouping Software for each EAPG grouper version.

"EAPG" means Enhanced Ambulatory Patient Groups, as defined in the EAPG grouper, which is a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. Services provided in each EAPG have similar clinical characteristics and similar resource use and cost.

"EAPG grouper" means the most recently released version of the EAPG software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during with the discharge occurred; except, for the calendar year beginning January 1, 2014, EAPG grouper means version 3.7 of the EAPG software.

"EAPG PPS" means the EAPG prospective payment system as described in this Section.

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"EAPG weighting factor" means, for each EAPG, the product, rounded to the nearest ten-thousandth, of:

the national weighting factor, as published by 3M Health Information Systems for the EAPG grouper; and

the Illinois experience adjustment.

"Estimated cost of outpatient base period claims data" means the product of:

outpatient base period paid claims data total covered charges;

the critical access hospital's aggregate ancillary cost-to-charge ratio; and

a rate year cost inflation factor.

"High outpatient volume" means the number paid outpatient claims described in subsection (b)(1) provided during the high volume outpatient base period paid claims data.

"High volume outpatient base period paid claims data" means SFY 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in SFY 2015 and 2016. For subsequent dates of service, the term means the SFY ending 30 months prior to the beginning of the calendar year during which the service is provided.

"Illinois experience adjustment" means, for the calendar year beginning January 1, 2014, a factor of 1.0; for subsequent calendar years, means the factor applied to 3M EAPG national weighting factors when updating EAPG grouper versions determined such that the arithmetic mean EAPG weighting factor under the new EAPG grouper version is equal to the arithmetic mean EAPG weighting factor under the prior EAPG grouper version using outpatient base period claims data.

"Labor-related share" means that portion of the statewide standardized amount that is allocated in the EAPG PPS methodology to reimburse the costs associated with personnel. The labor-related share for a hospital is 0.60.

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"Mean regional high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(1)(A) through (D), provided by hospitals within a region, based on outpatient base period paid claims data.

"Mean statewide high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(1)(A) through (D), provided by hospitals within the state, based on outpatient base period paid claims data.

"Medicare IPPS wage index" means for in-state providers and out-of-state Illinois Medicaid cost reporting providers, the wage index used for inpatient reimbursement as described in 89 Ill. Adm. Code 149.100. For out-of-state non-cost reporting providers, the wage index used to adjust the EAPG standardized amount shall be a factor of 1.0.

"Non-labor share" means the difference resulting from the labor-related share being subtracted from 1.0.

"Outpatient base period paid claims data" means SFY 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in SFY 2015, 2016 and 2017; for subsequent dates of service, the term means the most recently available adjudicated 12 months of outpatient paid claims data to be identified by the Department.

"Outpatient crossover paid claims data" means SFY 2011 outpatient Medicaid/Medicare dual eligible fee-for-service paid claims data, excluding renal dialysis claims and therapy claims, for EAPG PPS payment for services provided in SFY 2015, 2016 and 2017; for subsequent dates of service, the term means most recently available adjudicated 12-months of outpatient paid claims data to be identified by the Department.

"Packaging factor" means a factor of 0 percent applicable for services designated with a Packaging flag by the EAPG grouper under default EAPG settings plus EAPG 430 (CLASS I CHEMOTHERAPY DRUGS), EAPG 435 (CLASS I PHARMACOTHERAPY), EAPG 495 (MINOR CHEMOTHERAPY DRUGS), EAPG 496 (MINOR PHARMACOTHERAPY), and EAPGs 1001-1020

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(DURABLE MEDICAL EQUIPMENT LEVEL 1-20), and non-covered revenue codes defined in the Handbook for Hospital Services.

"Rate year cost inflation factor" means the cost inflation from the midpoint of the outpatient base period paid claims data to the midpoint of the rate year based on changes in Centers for Medicare and Medicaid Services (CMMS) input price index levels. For critical access hospital rates effective SFY 2015, the rate year cost inflation factor will be based on changes in CMMS input price index levels from the midpoint of SFY 2011 to SFY 2015.

"Region" means, for a given hospital, the rate region, as defined in 89 Ill. Adm. Code 140. Table J, within which the hospital is located.

"Total covered charges" means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMMS 1450), or one of its electronic transaction equivalents.

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

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- 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~~

- i) ~~Diagnostic and therapeutic group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2(a) procedures are~~

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- ~~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 circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual~~

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~~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(e)(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:~~
- i) ~~The rate for rehabilitation services provided by a hospital~~

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- ~~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;

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~~and physical rehabilitation, occupational or speech therapy services 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~~

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~~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 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.~~

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- 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 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~~

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- ~~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 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).~~

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- 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 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.~~
- e) ~~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.~~

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- 2) ~~For outpatient services or home dialysis treatments provided pursuant to Section 148.40(e)(2) or (e)(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(e)(2) or (e)(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).~~

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- ~~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 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~~

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~~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.~~

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~~

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~~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 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.~~

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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.~~
- 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).~~

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- 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.~~
- g) ~~Freestanding Emergency Centers~~
~~A Freestanding Emergency Center (FEC), as defined in Section 148.25(h) of this Part, is eligible to enroll for reimbursement of emergency services. Reimbursement for the emergency services provided in an FEC shall be made at the applicable APL group rate identified in subsection (b) of this Section. Payment for salaried physician services performed in conjunction with an APL procedure shall be made in accordance with subsection (b) of this Section.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.150 Public Law 103-66 Requirements

- a) ~~All cost reporting hospitals deemed eligible to receive disproportionate share hospital (DSH) adjustment payments, in accordance with Section 148.120, are required, and non-DSH cost reporting hospitals are encouraged, to annually submit annually, on or before August 15 of the rate year in a form or format specified by the Department, at least the following information separated by inpatient and outpatient (including hospital-based clinic services) to the Department:~~
- 1) The dollar amount of Illinois Medicaid charges rendered in the base year.
 - 2) The dollar amount of hospital charity care charges rendered in the base

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year for uninsured patients.

- 3) The dollar amount of hospital bad debt, less any recoveries, rendered in the base year for uninsured patients.
- 4) The dollar amount of Illinois total hospital charges for care rendered in the base year.

b) Definitions

- 1) "Medicaid charges" means hospital charges for inpatient, outpatient and hospital-based clinic services provided to recipients of medical assistance under Title XIX of the Social Security Act.
- 2) "Total charges" means the total amount of a hospital's charges for inpatient, outpatient and hospital-based clinic services it has provided.
- 3) "Base year" means the hospital's cost reporting period, utilized in the current rate year disproportionate share determination, and as described in Section 148.120(i)(1).
- 4) "Hospital charity care charges" and "hospital bad debt" mean inpatient, outpatient and hospital clinic services provided to individuals without health insurance or other sources of third party coverage. For purposes of the previous statement in this subsection (b)(4), State or unit of local government payments made to a hospital on behalf of indigent patients (~~i.e., Transitional Assistance and State Family and Children Assistance~~) ~~is shall~~ not be considered to be a form of insurance or a source of third-party coverage. Therefore, unreimbursed charges for persons covered under these programs may be included. Charity care charges and bad debt cannot include unpaid co-pays or third party obligations of insured patients, contractual allowances, or the hospital's charges or reduced charges attributable to services provided under its obligation pursuant to the federal Hill-Burton Act (42 USC 291).

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.160 Payment Methodology for County-Owned Large Public Hospitals ~~in an~~

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Illinois County with a Population of Over Three Million

Effective for dates of outpatient services on or after July 1, 2014 and inpatient discharges on or after July 1, 2014:

- a) Inpatient Reimbursement Methodology
In accordance with 89 Ill. Adm. Code 149.50(b)(5)(e)(8), county-owned hospitals, as defined in Section 148.25(a)(1), ~~an Illinois county with a population greater than three million~~ are excluded from the DRG PPS for reimbursement for inpatient hospital services and are reimbursed on a per diem basis ~~in accordance with this Section~~.
- 1) Inpatient Per Diem Rate Calculation
County-owned hospital inpatient per diem rates are calculated as follows:
- A) Each county-owned hospital's inpatient base year costs, including operating capital and direct medical education costs, shall be calculated using inpatient base period claims data and Medicare cost report data with reporting periods matching the inpatient base period.
- B) The inpatient base year costs shall be inflated from the midpoint of the inpatient base period claims data to the midpoint of the time period for which rates are being set (rate period) based on an inflation methodology determined by the Department and approved by Centers for Medicare and Medicaid Services (CMMS).
- C) Calculate the sum of:
- i) The total hospital inflated base year costs, excluding non-Medicare crossover claims, in the inpatient base period claims data; and
- ii) Total uncovered Medicare crossover claim cost in the inpatient base period claims data.
- D) The inpatient per diem rate shall be the quotient of:

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- B) The outpatient base year costs shall be inflated from the midpoint of the outpatient base period claims data to the midpoint of the rate period based on an inflation methodology determined by the Department and approved by CMMS.
- C) EAPG standardized amounts shall be determined for each county-owned hospital such that simulated EAPG payments are equal to outpatient base period costs inflated to the rate period, based on outpatient based period paid claims data.
- D) EAPG standardized amounts shall be reduced if resulting payments exceed available HFS funding or the CMMS Upper Payment Limit.

2) Rate Updates and Adjustments

- A) County-owned hospital EAPG standardized amounts shall be updated on an annual basis using more recent outpatient base period claims data, Medicare cost report data, and costs inflation data.
- B) Restructuring Adjustments
Adjustments to outpatient base year costs, as described in subsection (b)(1), will be made to reflect restructuring since filing the base year costs reports. The restructuring must have been mandated to meet State, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR 405, Subpart D, (1982)) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring cost must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available cost reports to determine restructuring costs.

3) New hospitals, for which outpatient base period claims data or Medicare

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cost reports are not on file, will be reimbursed the EAPG standardized amount calculated in subsection (b)(1).

- 4) Review Procedure
The review procedure shall be in accordance with Section 148.320.

c) Definitions

"Inpatient base period paid claims data" means Medicaid fee-for-service inpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period.

"Outpatient base period paid claims data" means Medicaid fee-for-service outpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period, excluding crossover claims.

"Rate period" means the State fiscal year for which the county-owned hospital inpatient and outpatient rates are effective.

b) Base Year Costs

- 1) ~~The hospitals' base year operating costs shall be contained in the hospitals' audited cost reports (see 42-CFR 447.260 and 447.265 (1982)) for hospitals fiscal years ending between 20 and 31 months prior to the fiscal year for which rates are being set.~~
- 2) ~~The hospitals' base year capital related costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) of this Section.~~
- 3) ~~The hospitals' base year direct medical education costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) of this Section.~~
- 4) ~~The base year cost per diem shall be the sum of the operating cost per diem, capital related cost per diem and medical education cost per diem defined in subsections (b)(1) through (b)(3) of this Section.~~

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- ~~5) New hospitals, for which a base year cost report is not on file, will be reimbursed the per diem rate calculated in subsection (b)(4) of this Section and inflated in subsection (d)(1) of this Section.~~
- e) ~~Restructuring Adjustments~~
Adjustments to the base year cost per diem, as described in subsection (b)(4) of this Section, will be made to reflect restructuring since filing the base year cost reports. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost reports to determine restructuring costs. If audited cost reports become available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Illinois Department of Public Aid, Office of Health Finance, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance, between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year cost per diem, as described in subsection (b)(4), which is subject to the inflation adjustment described in subsection (d) of this Section.
- d) ~~Inflation Adjustment For Base Year Cost Report Inflation~~
- 1) ~~The base year cost per diem, as defined in subsection (b)(4) of this Section, shall be inflated from the midpoint of the hospitals' base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in subsection (b)(1) of this Section by the previous year's operating cost per diem.~~

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- 2) ~~Effective October 1, 1992, the final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.~~
- 3) ~~Effective July 1, 2003, the rate for hospital inpatient services shall be the rate calculated in accordance with subsections (d)(1) and (2) of this Section that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.~~
- e) ~~Review Procedure~~
~~The review procedure shall be in accordance with Section 148.310.~~
- f) ~~Applicable Inpatient Adjustments~~
- 1) ~~The criteria and methodology for making applicable adjustments to DSH hospitals, which are exempt from the DRG PPS, as described in subsection (a) of this Section, shall be in accordance with Section 148.120.~~
- 2) ~~The criteria and methodology for making applicable Medicaid Percentage Adjustments to hospitals which are exempt from the DRG PPS as described in subsection (a) of this Section are described in this Section.~~
- A) ~~The payment adjustment shall be \$150 plus \$2 for each one percent that the hospital's Medicaid inpatient utilization rate, as described in Section 148.120(k)(5), exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3), multiplied by 3.75. This payment adjustment is based on a rate year 1993 base rate and shall be trended forward to the current rate year for inflationary increases.~~
- B) ~~The amount calculated pursuant to subsection (f)(2)(A) of this Section shall be adjusted on October 1, 1995, and annually thereafter, by a percentage equal to the lesser of:~~

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- ~~i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or~~
 - ~~ii) The percentage increase in the statewide average hospital payment rate, as described in Section 148.120(k)(8) over the previous year's statewide average hospital payment rate.~~
 - ~~C) The amount calculated pursuant to subsections (f)(2)(A) through (f)(2)(B) of this Section shall be no less than the rate calculated in accordance with Section 148.120(g)(2) in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year, through July 1, 2002, 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 is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~
 - ~~D) Effective July 1, 2003, the Medicaid Percentage Adjustment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.~~
 - ~~E) The amount calculated pursuant to subsection (f)(2) of this Section shall be the Medicaid percentage adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~
- 3) ~~County Provider Adjustment.~~
- ~~A) Effective July 1, 1995, hospitals reimbursed under this Section shall be eligible to receive a county provider adjustment. The methodology used to determine the add-on payment amount is as follows:~~

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- ~~i) Beginning with July 1, 1995, hospitals under this Section shall receive \$15,500 per Medicaid inpatient admission in the base period.~~
 - ~~ii) The payments calculated under this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate share adjustment payments.~~
 - ~~iii) The payments made under this subsection shall be made on a quarterly basis.~~
- ~~B) County Provider Adjustment Definitions.~~
 - ~~i) "Base Period" means State fiscal year 1994.~~
 - ~~ii) "Medicaid Inpatient Admission" means hospital inpatient admissions provided in the base period, which were subsequently adjudicated by the Department through the last day of June, 1995, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns and Medicare/Medicaid crossover days.~~
- 4) Hospitals reimbursed under this Section shall receive supplemental inpatient payments. Effective with admissions on or after July 1, 1995, supplemental inpatient payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in subsection (b)(4) of this Section, as adjusted for restructuring, as described in subsection (c) of this Section, and as adjusted for inflation, as described in subsection (d) of this Section, and the sum of the calculated disproportionate share and Medicaid percentage per diem payments as described in Section 148.120 and subsection (f)(2) of this Section, by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991 through July 31, 1992. Effective July 1, 1995, the supplemental inpatient

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~~payments calculated under this subsection shall be no less than the supplemental inpatient rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid cost by the total allowable Medicaid days. Effective July 1, 2003, the supplemental inpatient payment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. The supplemental inpatient payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

- ~~g) Outlier Adjustments
Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.~~
- ~~h) Trauma Center Adjustments. Trauma center adjustments shall be made in accordance with Section 148.290(e).~~
- ~~i) Reductions to Total Payments
 - ~~1) Copayments. Copayments are assessed in accordance with Section 148.190.~~
 - ~~2) Third Party Payments. The requirements of Section 148.290(f)(2) shall apply.~~~~
- ~~j) Prepayment and Utilization Review
Prepayment and utilization review requirements shall be in accordance with Section 148.240.~~
- ~~k) Cost Reporting Requirements
Cost reporting requirements shall be in accordance with Section 148.210.~~

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(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.170 Payment Methodology for University-Owned Large Public Hospitals Organized Under the University of Illinois Hospital Act

Effective for dates of outpatient services on or after July 1, 2014 and inpatient discharges on or after July 1, 2014:

- a) Inpatient Reimbursement Methodology
In accordance with 89 Ill. Adm. Code 149.50(b)(5)(e)(8), a large public hospital, as defined in Section 148.25(a), is organized under the University of Illinois Hospital Act shall be excluded from the DRG PPS for reimbursement for inpatient hospital services and shall be reimbursed on a per diem basis in accordance with this Section.
- 1) Inpatient Per Diem Rate Calculation
University-owned hospital inpatient per diem rates are calculated as follows:
- A) Each University-owned hospital's inpatient base year costs, including operating, capital and direct medical education costs, shall be calculated using inpatient base period claims data and Medicare cost report data with reporting periods matching the inpatient base period.
- B) The inpatient base year costs shall be inflated from the midpoint of the inpatient base period claims data to the midpoint of the time period, for which rates are being set (rate period) based on an inflation methodology determined by the Department and approved by the Center for Medicare and Medicaid Services (CMMS).
- C) Calculate the sum of:
- i) The total hospital inflated base year costs, excluding non-Medicare crossover claims, in the inpatient base period claims data; and

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University-owned hospital outpatient EAPG standardized amount is calculated as follows:

- A) Each University-owned hospital's outpatient base year costs, including operating, capital and direct medical education costs, shall be calculated using outpatient base period claims data and Medicare cost report data with reporting periods matching the outpatient base period.
 - B) The outpatient base year costs shall be inflated from the midpoint of the outpatient base period claims data to the midpoint of the rate period based on an inflation methodology determined by the Department and approved by CMMS.
 - C) EAPG standardized amounts shall be determined for each State-owned hospital such that simulated EAPG payments are equal to outpatient base period costs inflated to the rate period, based on outpatient based period paid claims data.
 - D) EAPG standardized amounts shall be reduced if resulting payments exceed available Department funding or the Centers for Medicare and Medicaid Services Upper Payment Limit.
- 2) Rate Updates and Adjustments
State-owned hospital EAPG standardized amounts shall be updated on an annual basis using more recent outpatient base period claims data, Medicare cost report data and cost inflation data.
- 3) Review Procedure
The review procedure shall be in accordance with Section 148.310.
- c) Definitions
"Inpatient base period paid claims data" means Medicaid fee-for-service inpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period.

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"Outpatient base period paid claims data" means Medicaid fee-for-service outpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period, excluding crossover claims.

"Rate period" means the State fiscal year for which the University-owned hospital inpatient and outpatient rates are effective.

b) ~~Base Year Costs~~

- ~~1) Each hospital's base year cost per diem shall be derived from an audited cost report (see 42 447.260 and 447.265 (1982)) for hospitals' fiscal year 1992.~~
- ~~2) For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.~~

e) ~~Restructuring Adjustment~~

~~Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Illinois Department of Public Aid, Office of Health Finance, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first~~

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~~day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year costs.~~

- d) ~~Inflation Adjustment For Base Year Cost Report Inflation~~
Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases.
- e) ~~Review Procedure~~
The review procedure shall be in accordance with Section 148.310.
- f) ~~Applicable adjustments for DSH Hospitals~~
- 1) ~~The criteria and methodology for making applicable adjustments to DSH hospitals, which are exempt from the DRG-PPS as described in subsection (a) of this Section, shall be in accordance with Section 148.120.~~
 - 2) ~~Effective October 1, 1993, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall have supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's base year costs, as described in subsection (b) of this Section, as adjusted for restructuring, as described in subsection (c) of this Section, and as adjusted for inflation, as described in subsection (d) of this Section, and the calculated disproportionate share per diem payment adjustment, as described in Section 148.120, by the hospital's percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 4.50 and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

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- g) ~~Outlier Adjustments~~
~~Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.~~
- h) ~~Reductions to Total Payments~~
 - 1) ~~Copayments. Copayments are assessed in accordance with Section 148.190.~~
 - 2) ~~Third Party Payments. The requirements of Section 148.290(f)(2) shall apply.~~
- i) ~~Prepayment and Utilization Review~~
~~Prepayment and utilization review requirements shall be in accordance with Section 148.240.~~
- j) ~~Cost Reporting Requirements~~
~~Cost reporting requirements shall be in accordance with Section 148.210.~~
- k) ~~Rate Period~~
~~The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year, except for the period of July 1, 1995, through September 30, 1995.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act (Repealed)

- a) ~~The Department shall make supplemental disproportionate share (DSH) payments in accordance with this Section to hospitals that meet all of the following requirements:~~
 - 1) ~~Qualify for DSH payment adjustments in accordance with Section 148.120(a).~~

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- 2) ~~Are organized under the Town Hospital Act [60 ILCS 170].~~
- 3) ~~Have entered into an agreement, approved by the Director.~~
- b) ~~Review Procedure~~
~~The review procedure shall be in accordance with Section 148.310.~~
- e) ~~Applicable Adjustments for Disproportionate Share Hospitals (DSH)~~
 - 1) ~~The criteria and methodology for making applicable adjustments to government owned DSH hospitals as described in subsection (a) above, shall be in accordance with Section 148.120.~~
 - 2) ~~Effective with dates of service on or after May 12, 1995, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall be eligible for supplemental DSH payments. Effective with admissions on or after May 12, 1995, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's alternate cost per diem rate in effect on May 12, 1995, as described in Sections 148.260, 148.270, and 89 Ill. Adm. Code 152.200, and the calculated disproportionate share per diem payment adjustment in effect on May 12, 1995, as described in Section 148.120, by the hospital's percentage of charges which are not reimbursed by a third party payor for the period of August 1, 1991 through July 31, 1992. The resulting product shall be multiplied by 6.25 and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided. The supplemental DSH payments cannot exceed the amount the hospital certifies as costs eligible for Federal Financial Participation under Title XIX of the Social Security Act.~~
 - 3) ~~DSH adjustments made under this subsection are subject to the DSH adjustment limitations described in Section 148.120(j).~~
- d) ~~Rate Period~~
~~The rate period for hospitals reimbursed under this Section shall be the 12 month~~

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~~period beginning on October 1 of the year and ending September 30 of the following year, except for the period of May 12, 1995 through September 30, 1995.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.180 Payment for Pre-operative Days and, Patient Specific Orders, ~~and Services Which Can Be Performed in an Outpatient Setting~~

Effective for dates of discharge on or after July 1, 2014:

- a) Pre-operative Days. For hospitals and distinct part units reimbursed on a per diem basis under Sections 148.105, 148.110, 148.116, 148.160 or, 148.170 ~~or 148.250 through 148.300~~, payment for pre-operative days shall be limited to the day immediately preceding surgery unless the attending physician has documented the medical necessity of an additional day or days. The documentation must be kept in the patient's medical record and must consist of a written notation made by the physician which documents that more than one pre-operative day is medically necessary.
- b) Inpatient Procedures Requiring Justification
 - 1) ~~A list of restricted inpatient procedures has been established. These restricted inpatient procedures will only be reimbursed when performed outside the inpatient setting or when the hospital supplies justification for an inpatient admission that meets Departmental established criteria. These criteria include, but are not limited to:~~
 - A) ~~Presence of medical conditions which make prolonged post-operative observations by a nurse or skilled medical personnel a necessity (e.g., heart disease, severe diabetes);~~
 - B) ~~The patient is in the hospital as an inpatient for a medically necessary condition unrelated to the surgical procedure;~~
 - C) ~~An unrelated procedure is being done simultaneously which itself requires surgical hospitalization;~~

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- D) ~~The practitioner has documented the medical necessity of performing the patient's surgery in an inpatient setting;~~
 - E) ~~The patient is unable to comprehend and/or follow the necessary instruction both prior to and following the procedure due to mental and/or physical impairment, and this would result in inadequate treatment and place the patient at risk;~~
 - F) ~~Emergency admission or recent onset of severe symptoms would prohibit safely performing the procedure on an outpatient basis (e.g., bleeding, severe pain, nausea, vomiting); and~~
 - G) ~~Admission occurs subsequent to the performance of the procedure on an outpatient basis due to conditions such as:~~
 - i) ~~Instability of vital signs;~~
 - ii) ~~Respiratory distress greater than existed pre-operatively;~~
 - iii) ~~Post-operative pain not relieved by oral medication;~~
 - iv) ~~Uncontrollable bleeding;~~
 - v) ~~Lack of state of consciousness appropriate to age and development;~~
 - vi) ~~Presence of persistent nausea or vomiting; and~~
 - vii) ~~Inability to ambulate consistent with age, previous mobility status and/or procedure.~~
- 2) ~~The list of procedures identified as restricted inpatient procedures which may be safely performed outside the inpatient setting and do not require an inpatient admission are reevaluated periodically.~~
- 3) ~~Additions to and deletions from the list of designated restricted inpatient procedures will be made following notice to and consultations with the Department's professional advisory committees, State Medicaid Advisory~~

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~~Committee, representatives selected by the hospitals, other third party payors, the Illinois Hospital Association, and other interested groups or individuals.~~

be) Ancillary Services and Tests

- 1) Ancillary services and routine tests (those services other than routine room and board and nursing which are required because of the patient's medical condition, including lab tests and x-rays) shall not be covered unless there is a patient specific written order for the test from the attending or operating physician responsible for the care and treatment of the patient. The attending or operating physician responsible for the care and treatment of the patient is required to sign all applicable sections for each test ordered in the appropriate place in the medical record. The order must be legible and explain completely all services or tests to be performed. Standing orders are not acceptable.
- 2) Upon completion of the service or test, a fully documented description of results with findings, or the administration of medication, must be maintained in the patient medical records. Radiological services must have the actual x-rays and the interpretation report; laboratory/pathological tests must have the specific findings for each test; and drugs and pharmaceutical supplies must indicate strength, dosages and durations.
- 3) Charges for any and all such services or tests cannot exceed those charged to the general public. The failure to maintain and provide records as described in this Section shall result in the disallowance of the applicable charges upon audit.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.200 Alternate Reimbursement Systems (Repealed)

- a) ~~Section 148.210 discusses cost reporting requirements for all hospitals participating in the Medicaid Program.~~
- b) ~~Section 148.220 describes the payment methodology for hospital inpatient~~

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~~services to recipients for admissions occurring prior to September 1, 1991.~~

- e) ~~The payments described in Sections 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992, subject to the provisions of Section 148.20(b).~~
- d) ~~The payments described in Section 148.82 shall be effective for admissions on and after September 1, 1991, with the exception of provisions that relate to pancreas or kidney pancreas transplants. Provisions relating to pancreas or kidney pancreas transplants shall be effective for admissions on and after July 1, 1992.~~
- e) ~~Sections 148.250 through 148.300 describe the payment methodologies for hospital inpatient services to recipients of Medical Assistance provided by a hospital not reimbursed under the DRG Prospective Payment System (PPS) described in 89 Ill. Adm. Code Part 149 or the reimbursement methodologies described in Sections 148.82, 148.160 and 148.170.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.210 Filing Cost Reports

- a) ~~Excepting those operated by an agency of the United States government, all All~~ hospitals in Illinois ~~and, those~~ hospitals in contiguous states providing 100 or more paid acute inpatient days of care to ~~the~~ Illinois Medicaid Program participants, ~~and all hospitals located in states contiguous to Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)),~~ shall be required to file Medicaid and Medicare cost reports within 150 days after the close of that provider's fiscal year. Any hospital accredited by TJC not eligible for or subject to Medicare certification shall be required to file financial statements, a statement of revenues and expenses by program and census logs by program and financial class. The Bureau of Health Finance may request an audit of the financial statements by an independent Certified Public Accountant (CPA) firm if the financial statements are to be used as the base year for rate analysis.
- 1) ~~Any hospital certified in the Medicare Program (Title XVIII) and electing, for the first time, to be reimbursed under the DRG PPS must include a~~

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~~copy of the two most recently audited Medicare cost reports at the time of enrollment.~~

- 2) ~~Any hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) not eligible for or subject to Medicare certification shall be required to file financial statements, a statement of revenues and expenses by program, and census logs by program and financial class. The Office of Health Finance may request an audit of the financial statements by an independent Certified Public Accountant (CPA) firm if the financial statements are to be used as the base year for rate analysis. Should the hospital elect not to comply with the audit request, or the financial statements are given other than an unqualified opinion, the hospital will receive an alternate rate as described in Section 148.270.~~

- b) No extension of the Medicaid cost report due date will be granted by the Department unless the Centers for Medicare and Medicaid Services (CMMSCMS) grants an extension of the due date for the related Medicare cost report. Should ~~CMMSCMS~~ extend the Medicare cost report due date, the Department will extend the Medicaid and Medicare cost reports due date by an equivalent period of time.
- c) If the hospital has not filed the required Medicaid cost reports within 150 days after the close of the hospital's fiscal year, the Department shall suspend payment for covered medical services until the Department receives the required information.
- d) ~~The assessment or license fees described in 89 Ill. Adm. Code 140.82, 140.84, 140.94 and 140.95 may not be reported as allowable Medicaid costs on the Medicaid cost report.~~
- e) Cost Report Reviews
The Bureau of Health Finance shall audit the information shown on the cost reports. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report, which may contain adjustments and revisions that may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. The request must

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be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. The request shall include all items of documentation and analysis that support the request for review. No additional data shall be accepted after the 45 day period.

- f) Hospitals described in Section 148.25(a)(1) and (a)(2) shall be required to submit outpatient cost reports to the Department within 150 days after the close of the facility's fiscal year.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.220 Pre September 1, 1991, Admissions (Repealed)

~~Reimbursement to hospitals for claims for admissions occurring prior to September 1, 1991 will be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.230 Admissions Occurring on or after September 1, 1991 (Repealed)

~~Reimbursement to hospitals not reimbursed under the DRG PPS (see 89 Ill. Adm. Code 149) or the reimbursement methodologies established at Sections 148.82, 148.160 and 148.170 for inpatient admissions occurring on or after September 1, 1991 shall be calculated in accordance with Sections 148.250 through 148.300, subject to the provisions of Section 148.20(b).~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements

Effective for dates of discharge on or after July 1, 2014:

- 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, ~~2013~~~~2004~~). A peer review shall be conducted by a Physician Peer Reviewer who is licensed to practice medicine in all its

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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. 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, pre-payment, and post-payment reviews to determine, pursuant to 42 CFR 476, Subpart C (October 1, ~~2013~~~~2004~~), 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:

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- 1) Assessment of appropriate level of care;
 - 2) The service could be furnished more economically on an outpatient basis;
 - 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) **Pre-payment Review**

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The Department may require hospitals to submit claims to the Department for pre-payment review and approval prior to rendering payment for services provided.

- f) **Post-payment Review**
Post-payment 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 post-payment 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, ~~2013~~~~2004~~). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code ~~148.25(d)(1)~~~~149.50(e)(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.

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- 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 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 withholding Medicaid~~ payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
 - B) ~~Termination termination~~ of the hospital's Provider Agreement.
- i) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

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- 1) The applicable payments made under this Part and 89 Ill. Adm. Code 149 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.~~
 - 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

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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 ~~does~~, in fact, bill private patients and collect and retain the payments received.

- v) A physician holding a nonteaching administrative or staff 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 (~~2013~~~~October 1, 2004~~).

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
(Repealed)

~~The exempt hospitals, defined in 89 Ill. Adm. Code 149.50(e)(1), (e)(2), (e)(4) and (e)(7), shall be reimbursed for inpatient hospital care provided to recipients by summing the following reimbursement calculations:~~

- a) ~~allowable operating cost per diem;~~
- b) ~~capital costs reimbursed on a per diem basis;~~

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- e) ~~applicable DSH adjustments as described in Section 148.120 and outlier adjustments as described in Section 148.130; and~~
- d) ~~applicable trauma center adjustments, as described in Section 148.290(c), and Medicaid high volume adjustments, as described in Section 148.290(d).~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.260 Calculation and Definitions of Inpatient Per Diem Rates (Repealed)

- a) ~~Calculation for the first rate year period~~
 - 1) ~~Allowable operating cost per diem~~
 - A) ~~The allowable operating cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units described in Section 148.270(a) and (b), shall be calculated by taking the hospital's Medicaid inpatient operating costs for the base period defined in Section 148.25(g)(1) divided by the hospital's Medicaid inpatient days.~~
 - B) ~~Operating cost base per diem rates for hospital inpatient care provided to Medicaid recipients beginning September 1, 1991, shall be calculated by:~~
 - i) ~~Calculating each individual hospital's cost per diem less capital and direct medical education costs for each of the two most recent years for which an audited Medicaid cost report exists, as described in subsection (a)(1)(A) above.~~
 - ii) ~~Each of the two costs per diem shall be trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~
 - iii) ~~These two trended operating costs per diem are then added together and divided by two.~~
 - iv) ~~The average operating cost per diem calculated in~~

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~~subsection (a)(1)(B)(iii) above is then divided by the indirect medical education (IME) factor, determined by the Health Care Financing Administration (HCFA), in effect ninety days prior to the admission in order to calculate the hospital's final operating cost per diem for the base period. For other hospitals for which an indirect medical education factor is not available, the Department shall calculate an indirect medical education factor using the hospital's most recently available cost report and the Medicare formula in effect 90 days prior to the date of admission.~~

- 2) ~~Capital Related Costs. The capital related cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking the hospital's total capital related costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~
- A) ~~These two trended capital related costs per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.~~
- B) ~~The adjusted capital related cost per diem, as calculated in subsection (a)(2)(A) above, shall be rank ordered for all hospitals and capped at the 80th percentile.~~
- C) ~~Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (a)(2)(A) or subsection (a)(2)(B) above, whichever is less.~~
- 3) ~~Direct Medical Education Costs. The direct medical education cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking total inpatient direct medical education costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~

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- A) ~~The two trended direct medical education costs per diem are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.~~
 - B) ~~The adjusted direct medical education cost per diem, as calculated in subsection (a)(3)(A) above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.~~
 - C) ~~Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in subsection (a)(3)(A) or subsection (a)(3)(B) above, whichever is less.~~
- b) ~~Calculation for Subsequent Rate Periods~~
- 1) ~~For the rate period described in Section 148.25(g)(2)(A), the final rate per diem shall be determined by taking the operating, capital and direct medical education trended rate costs per diems calculated under subsection (a) of this Section and updating those costs by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(A).~~
 - 2) ~~For rate periods beginning on or after April 1, 1994, as described in Section 148.25(g)(2)(B), the final rate per diem shall be determined by:~~
 - A) ~~Adding the operating and capital trended rate cost per diems calculated under subsection (a) of this Section that were in effect on June 30, 1993;~~
 - B) ~~Updating the trended rate cost per diems described in subsection (b)(2)(A) above;~~
 - i) ~~In the case of a hospital described in 89 Ill. Adm. Code 149.125(b), by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(B); and~~

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- ii) ~~In the case of a hospital described in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), or (c)(4), or for a hospital unit described in 89 Ill. Adm. Code 149.50(d)(1) or (d)(2), to the midpoint of the current rate period described in Section 148.25(g)(2)(B) by utilizing the TEFRA price inflation factor.~~
- e) **Rebasing**
~~For the rate period beginning after October 1, 1994, and every third rate period thereafter, the final rate per diem shall be calculated using the methodology set forth in subsection (a) of this Section for the calculation of operating and capital trended rate cost per diems using base period cost reports, as described in Section 148.25(g)(1).~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 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 (Repealed)

- a) ~~Calculation of Alternate Cost Per Diem Rates for All Hospitals~~
~~For all hospitals, regardless of the hospital's reimbursement methodology, the Department shall first calculate the hospital's alternate cost per diem rate, as calculated under Section 148.260, derived from the provider's base period cost reports, as described in Section 148.25(g)(1).~~
- b) ~~Calculation of Payment Rates for Certain Exempt Hospital Units~~
 - 1) ~~For admissions occurring within the rate period described in Section 148.25(g)(2)(A):~~
 - A) ~~In the case of a distinct part unit, as described in 89 Ill. Adm. Code 149.50(d), the Department shall divide the hospital's Medicaid charges per diem (identified on adjudicated claims submitted by the provider during the most recently completed fiscal year for which complete data are available) related to the distinct part unit by the hospital's total charge per diem for all claims for the same time period.~~

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- B) ~~The resulting quotient, as calculated in subsection (b)(1)(A), shall be multiplied by the hospital's total operating cost per diem, as calculated in Section 148.260(a)(1)(B).~~
 - C) ~~The capital related cost per diem, as calculated in Section 148.260(a)(2), is then added to the resulting product calculated in subsection (b)(1)(B), subject to the inflation adjustment described in Section 148.260(c)(1).~~
 - D) ~~Subject to the provisions of subsections (b)(1)(E) and (b)(1)(F), the final distinct part unit payment rate shall be the lower of:
 - i) ~~The result of the calculations described in subsections (b)(1)(A) through (b)(1)(B); or~~
 - ii) ~~The hospital's alternate cost per diem rate, as calculated in subsection (a) of this Section.~~~~
 - E) ~~In no case shall the hospital's final distinct part unit payment rate be greater than three standard deviations above the mean distinct part unit payment rate.~~
 - F) ~~In the case of a new distinct part unit for which the Department has insufficient adjudicated claims history data available, the Department shall utilize the average payment rate calculated under this subsection (b)(1) for like distinct part units.~~
- 2) ~~For admissions occurring within a rate period described in Section 148.25(g)(2)(B), the distinct part unit payment rate shall be the distinct part unit payment rate in effect on June 30, 1993, as calculated under subsection (b)(1), updated to the midpoint of the current rate period, using the TEFRA price inflation factor.~~
- e) ~~In the case of a new hospital (not previously owned or operated), a hospital that has significantly changed its case mix profile (e.g., a general acute care hospital changing its case mix to reflect a predominance of long term care patients), or an out-of-state non-cost reporting hospital, reimbursement for inpatient services shall~~

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be as follows:

- 1) ~~For general acute care hospitals, reimbursement for inpatient services:~~
 - A) ~~provided by Illinois general acute care hospitals prior to July 1, 2007 shall be at the average payment rate calculated under subsection (a) or (b), as applicable, for those hospitals that would otherwise be reimbursed under 89 Ill. Adm. Code 149.~~
 - B) ~~provided by Illinois general acute care hospitals on or after July 1, 2007 shall be reimbursed at either of the following:~~
 - i) ~~utilizing the payment methodologies described in 89 Ill. Adm. Code 149 that will only reflect the federal/regional blended rate described in 89 Ill. Adm. Code 149.100 and a capital rate equal to one standard deviation above the mean capital rate, as determined in 89 Ill. Adm. Code 149.150(e), for all providers reimbursed under the same federal/regional blended rate; or~~
 - ii) ~~at the average payment rate calculated under subsection (a) or (b), as applicable, for those hospitals that would otherwise be reimbursed under 89 Ill. Adm. Code 149.~~
 - C) ~~provided by out of state general acute care hospitals shall be at the average payment rate calculated under subsection (a) or (b), as applicable, for those hospitals that would otherwise be reimbursed under 89 Ill. Adm. Code 149.~~
- 2) ~~For psychiatric hospitals, as defined in 89 Ill. Adm. Code 149.50(e)(1):~~
 - A) ~~for services provided by a psychiatric hospital that began operation on or after January 1, 2008, that is devoted exclusively to the care of individuals who have not attained 19 years of age, reimbursement for inpatient psychiatric services shall be at the arithmetic mean of the rates defined in subsections (e)(2)(B) and (e)(5)(A) of this Section.~~

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- ~~B) for all other psychiatric hospitals, reimbursement for inpatient psychiatric services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(1).~~
- ~~3) For rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), reimbursement for inpatient rehabilitation services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(2).~~
- ~~4) For long term stay hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(4), reimbursement for inpatient services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(4).~~
- ~~5) For children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), reimbursement for inpatient services:~~
- ~~A) provided before August 1, 1998, shall be at the average rate calculated under subsection (a) for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(3);~~
- ~~B) provided on or after August 1, 1998, for a children's hospital that was licensed as such by a municipality after June 30, 1995, shall be equal to the average rate calculated in Section 148.280 for children's hospitals in existence before June 30, 1995, with an average length of stay that was less than 14 days as determined from the hospital's fiscal year 1994 cost report.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements (Repealed)

- ~~a) Children's Hospitals~~
- ~~1) Initial Rate Period~~

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- A) ~~For purposes of reimbursement, all children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), are grouped into one peer group.~~
- B) ~~Each hospital's costs for the base period shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending during calendar year 1989.~~
- C) ~~These base period costs shall be updated, trended forward from the midpoint of each hospital's base period to the midpoint of the rate period for which rates are being set, according to the methodology of the national total hospital market basket price proxies, (DRI).~~
- D) ~~The children's hospitals' base period trended rates shall be used as the basis for calculating the group's median trended rate. Each individual hospital's trended rate is then compared to the group's median trended rate. Hospitals whose individual trended rates are higher than the median rates shall receive as a final inpatient payment rate their trended rate minus half the difference between their trended rate and the group's median trended rate. Hospitals whose trended rates are lower than the group's median trended rate shall receive as final inpatient payment rate their individual trended rate plus half the difference between their trended rate and the group's median trended rate.~~
- 2) ~~Subsequent Rate Periods~~
~~For the rate period beginning on October 1, 1992, as described in Section 148.25(g)(1)(A), and for subsequent rate periods, as described in Section 148.25(g)(1)(B), the initial rate, as calculated under subsection (a)(1) above, shall be updated from the midpoint of the base cost reporting period to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~
- b) ~~Hospitals Reimbursed Under Special Arrangements~~
~~Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991,~~

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~~subject to the limitations described in Sections 148.40(e) through 148.40(g).~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.290 Adjustments and Reductions to Total Payments

Effective for dates of outpatient services on or after July 1, 2014 and inpatient discharges on or after July 1, 2014:

- a) The adjustments described in this Section, as applicable, shall be made to reimbursement amounts calculated pursuant to Sections 148.105, 148.110, 148.115, 148.140, 148.160, 148.170, 148.330 and 89 Ill. Adm. Code 149.100 prior to payment. The adjustments are to be applied in the order in which they are listed in this Section.
- b) Adjustments to base rates made pursuant to 89 Ill. Adm. Code 152.150.
- c) Increases in Payments. Supplemental payments pursuant to the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155] in accordance with Section 148.115(f).
- d) Reductions in Payments. The Department's payment obligation shall be reduced by:
 - 1) Charges. Except for reimbursement calculated under Sections 148.140, 148.160 and 148.170, payment shall not exceed the lesser of:
 - A) The reimbursement amount determined pursuant to subsections (a) and (b).
 - B) The allowable charges billed to the Department on the claim.
 - 2) Hospital Rate Reductions. Payment shall be reduced pursuant to the provisions of 89 Ill. Adm. Code 152.100.
 - 3) Third-party Liability. Hospitals shall determine whether services are covered, in whole or in part, under any program or under any other private group indemnification or insurance program or managed care entity. To

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the extent that coverage is available, the Department's payment obligation shall be reduced.

- 4) Copayments. Copayments are assessed in accordance with Section 148.190.
- e) Increases in Payments. The Department's payments obligations shall be increased, if applicable, by:
 - 1) Medicaid high volume adjustment payments pursuant to Section 148.112.
 - 2) Medicaid percentage adjustment payments pursuant to Section 148.122.
 - 3) DSH adjustment payments pursuant to Section 148.120.
- a) Applicable Adjustments for DSH

The criteria and methodology for making applicable DSH adjustments to hospitals shall be in accordance with Section 148.120.
- b) Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130 for hospitals that are exempt from the DRG-PPS (see 89 Ill. Adm. Code 149).
- e) County Trauma Center Adjustment (TCA). Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by the Illinois Department of Public Health, shall receive an adjustment that shall be calculated as follows:
 - 1) The available funds from the Trauma Center Fund for each quarter shall be divided by each eligible hospital's (as defined in subsection (c)(4) of this Section) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter.
 - 2) The county trauma center adjustment payments shall not be treated as

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~~payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Public Aid Code.~~

- 3) ~~The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis.~~
- 4) ~~Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this subsection shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level I or a Level II trauma center as required for the adjustment described in subsection (c) of this Section. In these instances, the adjustments calculated under this subsection shall be pro-rated, as applicable, based upon the date that such recognition ceased.~~
- 5) ~~Trauma Center Adjustment Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments required by subsection (c) of this Section are as follows:~~
 - A) ~~"Available funds" means funds which have been deposited into the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and which have been appropriated by the Illinois General Assembly.~~
 - B) ~~"Medicaid trauma admission" means those claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA 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 839.3, 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~~

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~~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, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under 18 years of age.~~

- ~~C) "TCA base period" means State Fiscal Year 1991, for TCA payments calculated for the October 1, 1992 TCA rate period; State Fiscal Year 1992 for TCA payments calculated for the October 1, 1993, TCA rate period, etc.~~
- ~~D) "TCA rate period" means, beginning October 1, 1992, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.~~
- ~~E) "Trauma Center Fund" means the fund created for the purpose of distributing a portion of monies received by county circuit clerks for certain violations of laws or ordinances regulating the movement of traffic to Level I and Level II trauma centers located in the State of Illinois. The Trauma Center Fund shall also consist of all federal matching funds received by the Department as a result of expenditures made by the Department as required by subsection (c)(4) of this Section.~~
- d) Medicaid High Volume Adjustments (MHVA)
 - 1) For inpatient admissions occurring on or after October 1, 2003, the Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals that meet the following criteria:

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- A) ~~Be eligible to receive the adjustment payments described in Section 148.122 in the MHVA rate period; and~~
 - B) ~~Not be a county-owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B) in the MHVA rate period.~~
- 2) ~~Calculation of Medicaid High Volume Adjustments~~
- A) ~~Hospitals meeting the criteria specified in subsection (d)(1) of this Section shall receive a MHVA payment adjustment of \$60.~~
 - B) ~~For children's hospitals, as defined in Section 148.122 (a)(5), the payment adjustment calculated under subsection (d)(2)(A) of this Section shall be multiplied by 2.0.~~
 - C) ~~The amount calculated pursuant to subsections (d)(2)(A) and (d)(2)(B) of this Section shall be adjusted by the aggregate annual increase in the national hospital market price proxies (DRI) hospital cost index (Health Care Cost Review, published by Global Insight, 24 Hartwell Avenue, Lexington MA (2003). This incorporation by reference includes no later amendments or editions.) from the MHVA rate period 1993, as defined in Section 148.290(d)(4)(B), through the MHVA rate period 2003, and annually thereafter, by a percentage equal to the lesser of:~~
 - i) ~~The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or~~
 - ii) ~~The percentage increase in the statewide average hospital payment rate, as described in subsection (d)(4)(C) of this Section, over the previous year's statewide average hospital payment rate.~~
 - D) ~~The adjustments calculated under subsections (d)(2)(A) through (d)(2)(C) of this Section shall be paid on a per diem basis and shall~~

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~~be applied to each covered day of care provided.~~

- 3) ~~Medicaid High Volume Adjustment Limitations.~~ Hospitals that qualify for MHVA adjustments under subsections (d)(2)(A) through (d)(2)(C) of this Section shall not be eligible for such MHVA adjustments if they are no longer recognized or designated by the Department as a Medicaid Percentage Adjustment hospital, as required by subsection (d)(1) of this Section. In this instance, the annual adjustment described in subsections (d)(2)(A) through (d)(2)(C) of this Section shall be pro-rated, as applicable, based upon the date that the hospital was deemed ineligible for Medicaid percentage adjustment payments, under Section 148.122, by the Department.
- 4) ~~Medicaid High Volume Adjustment Definitions.~~ The definitions of terms used with reference to calculation of the MHVA adjustments required by subsection (d) of this Section are as follows:
- A) ~~"MHVA base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, MHVA determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, MHVA determination year, etc.~~
 - B) ~~"MHVA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.~~
 - C) ~~"Statewide Average Hospital Payment Rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).~~
- e) ~~Inpatient Payment Adjustments based upon Reviews.~~ Appeals based upon a hospital's ineligibility for the inpatient payment adjustments described in this Section, or their payment adjustment amounts, in accordance with Section 148.310, which result in a change in a hospital's eligibility for inpatient payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the inpatient payment adjustments of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for inpatient payment adjustments based upon the requirements of this Section.

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- f) ~~Reductions to Total Payments~~
- 1) ~~Copayments. Copayments are assessed in accordance with Section 148.190.~~
 - 2) ~~Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.295 Critical Hospital Adjustment Payments (CHAP)

Effective for dates of service on or after July 1, 2014, except those Sections specifically designated otherwise. Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(a)(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 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(e)(3), operating~~

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~~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.~~
 - 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~~

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- ~~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.~~
- 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~~

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~~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 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.~~

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- 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 December 31, 2014.~~

ae) Direct Hospital Adjustment (DHA) Criteria

- 1) **Qualifying Criteria**
Hospitals may qualify for the DHA under this subsection (a)(e) 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 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:

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- 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 ~~(a)(1)(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 ~~Section 148.125(d)(3)89-III. Adm. Code 149.50(e)(3)~~, on July 1, 1999.
- D) Illinois teaching hospitals; with more than 40 graduate medical education programs on July 1, 1999; not qualifying ~~under~~ subsection ~~(a)(e)(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 (e)(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.~~

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- ~~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.
- ~~E)~~ 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 (a)(e)(1)(A) through (a)(e)(1)(~~D~~)(~~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 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

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~~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 ~~(a)(e)(1)(A) of this Section~~ that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than 1.5 standard deviation above the Statewide mean Combined MIUR, will continue to receive the rate in effect as of December 31, 2013, \$105.00 per day for hospitals that do not provide obstetrical care and a rate of \$142.00 per day for hospitals that do provide obstetrical care, for dates of service through June 30, 2014. For dates of service on or after July 1, 2014, the rate is \$0.00., 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.~~

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~~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.~~

B) ~~Hospitals qualifying under subsection (a)(e)(1)(A) of this Section with an average length of stay less than 3.9 days will continue to receive the rate in effect as of December 31, 2013, \$254.00 per day, for dates of service on or after July 1, 2014, 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. For dates of service on or after January 1, 2015, the rate is \$131.00.~~

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- 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 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 receiving payments under subsection (a)(2)(A) that have an average length of stay less than four days will continue to have their rate increased by \$650.00 per day for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is increased by \$1,040.00 per day. For dates of service on or after July 1, 2014, the rate is \$0.00.~~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.~~

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ii) ~~Qualifying hospitals with more than 1,500 obstetrical days will have their rate increased by \$824.00 per day through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$369.00.~~

D) 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 continue to be increased by \$148.00 per day for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is increased by \$287.00 per day. For dates of service on or after July 1, 2014, the rate is \$0.00.~~Hospitals qualifying under subsection (e)(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.~~

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, 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; for~~

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~~dates of service on or after January 1, 2015, 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; for dates of service on or after January 1, 2015, 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 ~~(a)(1)(B)(e)(1)(D)~~ of this Section that have more than 1,500 obstetrical days will continue to receive the rate in effect as of December 31, 2013, \$224.00 per day, for dates of service on or after July 1, 2014. 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 \$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 December 31, 2014, this rate shall be further increased by \$54.00 per day, to \$95.00 per day.~~

F) Hospitals qualifying under subsection ~~(a)(1)(C)(e)(1)(E)~~ of this Section that are not located in Illinois, have an MIUR greater than 45 percent, and greater than 4,000 days will continue to receive the

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rate in effect as of December 31, 2013, \$117.00 per day, for dates of service on or after July 1, 2014.~~will receive \$188.00 per day.~~

- G) Hospitals qualifying under subsection (a)(1)(E) will continue to receive the rate in effect as of December 31, 2013, \$90.00 per day, for dates of service on or after July 1, 2014.~~Hospitals qualifying under subsection (c)(1)(F) of this Section will receive a rate of \$55.00 per day.~~
- H) Hospitals qualifying under subsection (a)(1)(D) with a combined MIUR that is equal to or greater than 35 percent will receive a rate of \$54.00 for dates of service on or after July 1, 2014.
- 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 calculated under this Section may be classified as disproportionate~~

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~~share adjustments for hospitals qualifying under subsection (e)(1)(A)(iii) of this Section.~~

3) DHA Payments

A) Payments under this subsection ~~(a)(e)~~ 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 (e)(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.~~

bg) 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~~Fiscal Year 1994 for CHAP calculated for the July 1, 1995 CHAP rate period; State ~~fiscal year~~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~~(i)(4)(k)(5)~~, plus the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120~~(i)(5)(k)(6)~~, as of July 1, 1999.
- 5) "Coordinated Care Participating Hospital" means a hospital that is located in a county 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, including an out-of-state hospital in a county contiguous to a managed care region that is one of the following:
 - A) Has entered into a contract to provide hospital services with one or more MCOs to enrollees of the care coordination program.

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- B) Has not been offered a contract by a care coordination plan that the Department has determined to be a good faith offer when the plan that pays not less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplement payment that the Department pays directly, except to the extent those adjustments or supplemental payments are incorporated into the development of the applicable MCO capitated rates.
- C) Is not licensed to serve the population mandated to enroll in the care coordination program.
- D) As used in this subsection (b)(5), "MCO" means any entity that contracts with the Department to provide services when payment for medical services is made on a capitated basis.
- 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.~~

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- 8) ~~"Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.~~
- 79) "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.
- 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.~~

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- ~~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.~~
- ~~814)~~ "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.
- ~~915)~~ "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.
- ~~1016)~~ "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 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th 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 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.296 Transitional Supplemental~~Fertiary Care Adjustment~~ Payments

Effective for dates of service on or after July 1, 2014, to provide stability to the hospital industry in the midst of replacing a twenty year old reimbursement system that relied heavily on non-claims based static payments, in favor of an updated APR-DRG grouper for inpatient services and an entirely new outpatient reimbursement methodology in the EAPG system, the Department shall create transitional supplemental payments to hospitals. These payments are essential to maintaining access to care for an expanding population of Illinois Medical Assistance recipients for a limited time period to allow the hospital providers time to adjust to the new reimbursement policies, rates and methodologies.

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- a) Transitional Supplemental Payments shall be made to providers with a simulated payment loss under the new inpatient and outpatient systems combined.
- 1) The following providers will not qualify for Transitional Supplemental Payments:
- A) University-owned large public hospitals, county-owned large public hospitals, children's specialty hospitals and non-cost reporting hospitals.
- B) Providers with a simulated payment gain under the new inpatient and outpatient systems combined.
- 2) Simulated payment loss or gain under the new inpatient and outpatient systems combined shall be based on:
- A) SFY 2013 legacy system reported claim payments: Reported payments in Illinois Medicaid FFS inpatient and outpatient paid claims data, including Medicare-Medicaid dual eligible claims and non-Medicare eligible claims, for claims with submittal dates during SFY 2013 and admission dates on or after July 1, 2011, excluding DSH payments outpatient therapy claims, and claims with invalid/ungroupable inpatient DRGs or outpatient EAPGs.
- B) SFY 2013 new system simulated claim payments: Simulated payments under the new inpatient and outpatient systems using SFY 2013 claims data described in subsection (a)(2)(A), including MPA/MHVA payments and excluding DSH payments and inpatient GME payment increases.
- C) SFY 2011 legacy system supplemental payments, excluding payments that will continue in current form in SFY 2015.
- D) All legacy and new system payment amounts used to determine Transitional Supplemental Payments will be adjusted for SMART Act reductions.

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- E) Estimated payment gain or loss under the combined new inpatient and outpatient systems shall be determined as follows: (Simulated new system SFY 2013 claim payments) – [(Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments)].
- b) Transitional Supplemental Payments for qualifying providers shall be equal to the estimated payment loss under the combined new inpatient and outpatient systems, as defined in subsection (a)(2)(E).
- c) Timing
 - 1) The Department shall make Transitional Supplemental Payments for the first four years of the new inpatient and outpatient payment systems effective during SFY 2015 through SFY 2018.
 - 2) Commencing January 2017, the Department shall convene a Technical Advisory Group to determine the need to continue any new supplemental payments to maintain access to care to be effective July 1, 2018. Any new supplemental payments may be based on one or more of the following considerations critical to maintaining access to care for those eligible for Medicaid services:
 - A) Provider-specific payment increases received from the Medicaid expansion population.
 - B) Provider-specific Medicaid volume (both total volume and Medicaid utilization rate).
 - C) Provider-specific new system payments compared to UPL cost.
 - D) Provider-specific new system payments compared to estimated payments under Medicare, using an aggregate Medicare payment-to-charge ratio.
 - E) Provider-specific payments under the hospital assessment.
 - F) Available inpatient and outpatient UPL gap for each provider class.

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- G) The financial implications of the loss of Transitional Supplemental Payments in excess of \$10,000,000 and have an MIUR at least of 1.5 standard deviations above the mean.
 - H) An analysis of new hospital revenues and losses from all sources.
- 3) Effective July 1, 2018, the Department shall direct unused funds from legacy Transitional Supplemental Payments to increase either inpatient DRG PPS base rates or EAPG PPS conversion factors, adjust current policy adjustors defined in Section 148.140(f) and 89 Ill. Adm. Code 149.100(f) if needed, and/or create new policy adjustors, which may include but are not limited to, Perinatal level II or II+ facilities and expensive drugs and devices if needed, based on analysis and recommendations from the Technical Advisory Group defined in subsection (c)(2). Tertiary Care Adjustment Payments shall be made to all eligible hospitals, excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), 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, 2002, in accordance with this Section.
- a) Definitions. The definitions of terms used with reference to calculation of payments under this Section are as follows:
- 1) "Base Period Claims" means claims for inpatient hospital services with dates of service occurring in the Tertiary Adjustment Base Period that were subsequently adjudicated by the Department through December 31, 1999. For a general care hospital that includes a facility devoted exclusively to caring for children and that was separately licensed as a hospital by a municipality before September 30, 1998, Base Period Claims for services that may, in 89 Ill. Adm. Code 149.50(c)(3), be billed by a children's hospital shall be attributed exclusively to the children's facility. Base Period Claims shall exclude the following types:
 - A) Claims for which Medicare was liable in part or in full ("cross-over" claims);

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- B) ~~Claims for transplantation services that were paid by the Department via form C-13, Invoice Voucher; and~~
 - C) ~~Claims for services billed for exceptional care services as described at Section 148.50(e)(2)(A) and (B).~~
- 2) ~~"Case Mix Index" or "CMI", for a given hospital, means the sum of all Diagnosis Related Grouping (DRG) (see 89 Ill. Adm. Code 149) weighting factors for Base Period Claims divided by the total number of claims included in the sum, but excluding claims:~~
- A) ~~Reimbursed under a per diem rate methodology; and~~
 - B) ~~For Delivery or Newborn Care.~~
- 3) ~~"Case Mix Adjustment Factor" or "CMAF" means the following:~~
- A) ~~For qualifying hospitals located in Illinois that, for Base Period Claims, had a CMI that is greater than the mean:~~
 - i) ~~CMI of all Illinois cost reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.040;~~
 - ii) ~~CMI plus one standard deviation above the mean of all Illinois cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.250;~~
 - iii) ~~CMI plus two standard deviations above the mean of all Illinois cost reporting hospitals, the CMAF shall be equal to 0.300.~~
 - B) ~~For qualifying hospitals located outside of Illinois that, for Base Period Claims, had a CMI that is greater than the mean:~~
 - i) ~~CMI of all out-of-state cost reporting hospitals, but less than that mean plus a one standard deviation above the~~

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~~mean, the CMAF shall be equal to 0.020;~~

- ~~ii) CMI plus one standard deviation above the mean of all out-of-state cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.125;~~
- ~~iii) CMI plus two standard deviations above the mean of all out-of-state cost reporting hospitals, the CMAF shall be equal to 0.150.~~

- ~~4) "Delivery or Newborn Care" means inpatient hospital care, the claim for which was assigned by the Department to DRGs 370 through 375, 385 through 387, 389, 391 and 985 through 989.~~
- ~~5) "Tertiary Adjustment Base Period" means calendar year 1998.~~
- ~~6) "Tertiary Care Adjustment Rate Period" means, for fiscal year 2001, the three-month period beginning April 1, 2001, and for each subsequent fiscal year, the twelve-month period beginning July 1.~~

b) ~~Case Mix Adjustment~~

~~The Department shall make a Case Mix Adjustment to certain hospitals, as defined in this subsection (b).~~

- ~~1) Qualifying Hospital. A hospital meeting both of the following criteria shall qualify for this payment:~~
 - ~~A) A hospital that had 100 or more Qualified Admissions; and~~
 - ~~B) For a hospital located:~~
 - ~~i) in Illinois, has a CMI greater than or equal to the mean CMI for Illinois hospitals; or~~
 - ~~ii) outside of Illinois, has a CMI greater than or equal to the mean CMI for out-of-state cost reporting hospitals.~~

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- 2) ~~Qualified Admission. For the purposes of this subsection (b), "Qualified Admission" shall mean a Base Period Claim excluding a claim:~~
- A) ~~Reimbursed under a per-diem rate methodology; and~~
 - B) ~~For Delivery or Newborn Care.~~
- 3) ~~Case Mix Adjustment. Each Qualifying Hospital will receive a payment equal to the product of:~~
- A) ~~The product of the hospital's:~~
 - i) ~~number of Qualified Admissions; and~~
 - ii) ~~CMAF; and~~
 - B) ~~The sum of the hospital's:~~
 - i) ~~rate for capital related costs in effect on July 1, 2000; and~~
 - ii) ~~the product of the hospital's CMI raised to the second power and the DRG PPS (Prospective Payment System) (see 89 Ill. Adm. Code 149) rate per discharge in effect on July 1, 2000.~~
- e) ~~DRG Adjustment~~
~~The Department shall make a DRG Adjustment to certain hospitals, as defined in this subsection (c).~~
- 1) ~~Qualifying Hospital. A hospital that, during the Tertiary Adjustment Base Period, had at least one Qualified Admission shall qualify for this payment.~~
 - 2) ~~Qualified Admission. For the purposes of this subsection (c), "Qualified Admission" means a Base Period Claim that was:~~
 - A) ~~Assigned by the Department to a DRG that:~~

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- ~~i) had been assigned a weighting factor greater than 3.2000; and~~
 - ~~ii) for which fewer than 200 Base Period Claims were adjudicated by the Department; and~~
 - ~~B) Not a claim:
 - ~~i) reimbursed under a per diem rate methodology;~~
 - ~~ii) for Delivery or Newborn Care; or~~
 - ~~iii) for a patient transferred to another facility as described at 89 Ill. Adm. Code 149.25(b)(2).~~~~
- ~~3) DRG Adjustment Rates. For each Qualified Admission, a Qualifying Hospital will receive a payment equal to the product of:
 - ~~A) The hospital's DRG PPS rate per discharge in effect on July 1, 2000; and~~
 - ~~B) The weighting factor assigned to the DRG to which the Qualified Admission was assigned by the Department; and~~
 - ~~C) The constant 1.400.~~~~
- ~~d) Children's Hospital Adjustment
The Department shall make a Children's Hospital Adjustment to certain hospitals, as defined in this subsection (d).
 - ~~1) Qualifying Hospital. A children's hospital, as defined at 89 Ill. Adm. Code 149.50(c)(3), shall qualify for this payment.~~
 - ~~2) Qualified Days. For the purposes of this subsection (d), "Qualified Day" means a day of care that was provided in a Base Period Claim, excluding a claim:
 - ~~A) For Delivery or Newborn Care;~~~~~~

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- B) ~~Assigned by the Department to a DRG with an assigned weighting factor that is less than 1.0000; or~~
 - C) ~~For hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b).~~
- 3) ~~Children's Hospital Adjustment. A Qualifying Hospital shall receive a payment equal to the product of:~~
- A) ~~The sum of Qualified Days from the hospital's Base Period Claims; and~~
 - B) ~~For Illinois hospitals with:~~
 - i) ~~more than 5,000 Qualified Days, \$670.00; or~~
 - ii) ~~5,000 or fewer Qualified Days, \$300.00.~~
 - C) ~~For out of state hospitals with:~~
 - i) ~~more than 1,000 Qualified Days, \$670.00; or~~
 - ii) ~~1,000 or fewer Qualified Days, \$300.00.~~
- e) ~~Primary Care Adjustment~~
~~The Department shall make a Primary Care Adjustment to certain hospitals, as defined in this subsection (e).~~
- 1) ~~Qualifying Hospital. A hospital located in Illinois that has at least one Qualifying Resident shall qualify for this payment.~~
 - 2) ~~Qualifying Residents. For the purposes of this subsection (e), "Qualifying Residents" means the number of primary care residents, as reported on form HCFA 2552-96, Worksheet E-3, Part IV, line 1, column 1, for hospital fiscal years ending September 30, 1997, through September 29, 1998, used in the fiscal year 2002 Tertiary Care Adjustment Rate Period.~~

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- 3) ~~Qualified Admission. For the purposes of this subsection (e), "Qualified Admission" shall mean a Base Period Claim excluding a claim:~~
- A) ~~For hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b) and reimbursed under a per diem rate methodology; and~~
 - B) ~~For Delivery or Newborn Care.~~
- 4) ~~Primary Care Adjustment. A Qualifying Hospital will receive a payment equal to the product of:~~
- A) ~~The number of Qualifying Admissions during the Tertiary Adjustment Base Period;~~
 - B) ~~\$4,675.00; and~~
 - C) ~~The quotient of:~~
 - i) ~~the number of Qualifying Residents;~~
 - ii) ~~divided by the number of Qualifying Admissions.~~
- f) ~~Long Term Stay Hospital Adjustment~~
~~The Department shall make a Long Term Stay Hospital Adjustment to certain hospitals, as defined in this subsection (f).~~
- 1) ~~Qualifying Hospital. A long term stay hospital, as defined at 89 Ill. Adm. Code 149.50(e)(4), that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, shall qualify for this payment.~~
 - 2) ~~Qualified Days. For the purposes of this subsection (f), "Qualified Day" means a day of care that was provided in a Base Period Claim, excluding claims for hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b).~~

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- 3) ~~Long Term Stay Hospital Adjustment Rates. A Qualifying Hospital will receive payments equal to the product of:~~
- A) ~~The number of Qualified Days from all Base Period Claims; and~~
 - B) ~~A constant that:~~
 - i) ~~for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals plus one standard deviation above the mean, \$3,000.00; or~~
 - ii) ~~for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, but less than one standard deviation above that mean, \$5.00.~~
- g) ~~Rehabilitation Hospital Adjustment~~
~~The Department shall make a Rehabilitation Hospital Adjustment to certain hospitals as defined in this subsection (g).~~
- 1) ~~Qualifying Hospital. A hospital that qualifies for the Rehabilitation Hospital Adjustment under the Critical Hospital Adjustment Payments (CHAP) program, as defined in Section 148.295(b), shall qualify for this payment.~~
 - 2) ~~Qualified Admission. For the purposes of this subsection (g), "Qualified Admission" shall mean a Medicaid level I rehabilitation admission in the CHAP rate period, as defined in Section 148.295, for fiscal year 2001.~~
 - 3) ~~Rehabilitation Hospital Adjustment. A Qualifying Hospital shall receive payment as follows:~~
 - A) ~~For a hospital that had fewer than 60 Qualified Admissions, \$100,000.00.~~
 - B) ~~For a hospital that had 60 or more Qualified Admissions, \$350,000.00.~~

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- h) ~~Tertiary Care Adjustment~~
- 1) ~~The total annual adjustment to an eligible hospital shall be the sum of the adjustments for which the hospital qualifies under subsections (a) through (g) of this Section multiplied by 0.455.~~
 - 2) ~~A total annual adjustment amount shall be paid to the hospital during the Tertiary Care Adjustment Rate Period in installments on, at least, a quarterly basis.~~
 - 3) ~~For hospitals qualifying for payments under this Section, adjustment periods occurring in State fiscal year 2009, total payments will equal the sum of amounts calculated under the methodologies described in this Section and shall be paid to the hospital during the Tertiary Care Adjustment Rate period.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.297 Physician Development Incentive Payments~~Pediatric Outpatient Adjustment Payments~~

Effective for dates of service on or after July 1, 2014:

- a) A Medicaid Graduate Medical Education (GME) fund in Illinois will support and align with the State's current and projected physician workforce needs and goals including:
 - 1) Increasing the number of primary care providers in Illinois;
 - 2) Increasing the number of primary care providers working in medically underserved areas; and
 - 3) Increasing the number of providers who are trained to practice in a patient-centered medical home setting within an integrated delivery system.
- b) The performance criteria for incentive payments of the program will be as follows:

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- 1) Resident Continuity Clinics
 - A) 50 percent of funds are set aside for GME program resident continuity clinics meeting standards for at least one of the following:
 - i) Level II or III Patient Centered Medical Homes by the National Center for Quality Assurance.
 - ii) Primary Care Medical Home Certification by the Joint Commission.
 - iii) Medical Home Accreditation by the Accreditation Association for Ambulatory Health Care.
 - B) Each program within a hospital meeting one of these certification or accreditation standards will receive an equal share of these funds.
- 2) Resident Practice Clinics
 - A) 25 percent of funds will be set aside for resident practice clinics with significant medically underserved populations.
 - B) Each program within a hospital meeting these standards will receive an equal share of these funds.
- 3) Continuity of Care Settings
 - A) 25 percent of funds set aside for written curricula in population medicine based on practice in continuity of care settings. The curriculum must contain competencies in population medicine. Population medicine curriculum competencies should include: preventive medicines; information technology for managing continuity of care practice panels; managing transitions of care; participating in team-based care and supporting patient-centered decision making. Programs must document that all residents received at least 20 hours a year in instruction in these areas.

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- B) Each program within a hospital meeting these standards will receive an equal share of these funds.
- c) Residency programs and the sponsoring medical centers will collect all information to be submitted for this program to HFS by June 1 each GME rate year. This includes, proof of certification requirements required in subsection (b)(1)(A), internal GME residency program data, and queries of GME program recent graduates.
- d) The submitted data from eligible GME programs will be reviewed for meeting program performance standards. The Department may require, for corroborating information and audit, any submission.
- e) All GME residency programs meeting performance standards and qualifying to receive program funding will be announced annually. Subsequent to its determination of qualifying programs, the Department will disburse program funds to the hospitals that sponsor qualifying GME residency programs.
- f) The Department shall recover, through repayment by or recoupment against other funds payable to the hospital, program funds that have been found to have been disbursed in error.
- g) Definitions
- 1) "GME" means graduate medical education.
 - 2) "GME rate year" means the 12-month period beginning on July 1 of each year, with the first GME rate year to begin on July 1, 2014.
 - 3) "Primary care GME programs" means either Accreditation Council on Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) Post Graduate accredited residency programs in Family Medicine, Internal Medicine, Pediatrics and Internal Medicine-Pediatrics. Programs that are dual accredited by the ACGME and AOA are only eligible for a single yearly payment.

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- 4) "Significant medically underserved populations" means more than 50% of the individuals served by a qualifying residency practice clinic are enrolled in Medicaid or are uninsured. The denominator used in this calculation shall include all resident continuity clinics in a GME program practice. When more than one site is used for resident continuity of care practice, the designated practice site or sites used to calculate percent medically underserved must contain greater than 75% of all patients seen by residents in continuity practice.

~~Pediatric Outpatient Adjustment Payments shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for outpatient services occurring on or after July 1, 1998, in accordance with this Section.~~

- a) ~~To qualify for payments under this Section, a hospital must:~~
- 1) ~~be a children's hospital, as defined in 89 Ill. Adm. Code 149.50(e)(3), and~~
 - 2) ~~have a Pediatric Medicaid Outpatient Percentage greater than 80 percent during the Pediatric Outpatient Adjustment Base Period.~~
- b) ~~Hospitals qualifying under this Section shall receive the following amounts for the Pediatric Outpatient Adjustment Rate Year for dates of services occurring on or after July 1, 1999:~~
- 1) ~~For out-of-state cost reporting hospitals with an MIUR that is less than 75 percent, the product of:~~
 - A) ~~the hospital's MIUR plus 1.15, multiplied by~~
 - B) ~~the number of Pediatric Adjustable Outpatient Services, multiplied by~~
 - C) ~~\$169.00.~~
 - 2) ~~For Illinois hospitals with an MIUR that is less than 75 percent, the product of:~~

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- A) ~~the hospital's MIUR plus one, multiplied by~~
 - B) ~~the number of Pediatric Adjustable Outpatient Services, multiplied by~~
 - C) ~~\$169.00.~~
- 3) ~~For Illinois hospitals with an MIUR that is greater than or equal to 75 percent, the product of:~~
- A) ~~one and one-half the hospital's MIUR plus one, multiplied by~~
 - B) ~~the number of Pediatric Adjustable Outpatient Services, multiplied by~~
 - C) ~~\$305.00.~~
- e) ~~In addition to the reimbursement rates described in subsection (b) of this Section, hospitals that have an MIUR that is greater than or equal to 80 percent shall receive an additional \$229,740.00 during the Pediatric Outpatient Adjustment Rate Year.~~
- d) ~~Adjustments under this Section shall be paid at least quarterly.~~
- e) ~~Definitions~~
- 1) ~~"Medicaid Inpatient Utilization Rate" or "MIUR", as used in this Section, has the same meaning as ascribed in Section 148.120(i)(5), in effect for the rate period October 1, 1996, through September 30, 1997.~~
 - 2) ~~"Pediatric Adjustable Outpatient Services" means the number of outpatient services, excluding procedure code 0080, adjudicated through a UB92 billing form and grouped through the Hospital Ambulatory Care Groupings, as defined in Section 148.140(b)(1), during the Pediatric Outpatient Adjustment Base Period. For a hospital, which includes a facility devoted exclusively to caring for children, that is separately licensed as a hospital by a municipality, Pediatric Adjustment Outpatient Services will include psychiatric services (categories of service 27 or 28)~~

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- ~~for children less than 18 years of age, that are billed through the affiliated general care hospital.~~
- 3) ~~"Pediatric Medicaid Outpatient Percentage" means a percentage that results from the quotient of the total Pediatric Adjustable Outpatient Services for persons less than 18 years of age divided by the total Pediatric Adjustable Outpatient Services for all persons, during the Pediatric Outpatient Adjustment Base Period.~~
- 4) ~~"Pediatric Outpatient Adjustment Base Period" means all services billed to the Department, excluding procedure code 0080, with State Fiscal Year 1996 dates of service that were adjudicated by the Department on or before March 31, 1997.~~
- 5) ~~"Pediatric Outpatient Adjustment Rate Year" means State Fiscal Year 1998 and each State Fiscal Year thereafter.~~
- f) ~~For hospitals qualifying for payments under this Section, adjustment periods occurring in State fiscal year 2009, total payments will equal the sum of amounts calculated under the methodologies described in this Section and shall be paid to the hospital during the Pediatric Outpatient Adjustment Rate year.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.298 Pediatric Inpatient Adjustment Payments (Repealed)

~~Pediatric Inpatient Adjustment Payments shall be made, on a quarterly basis, to all eligible hospitals excluding county owned hospitals, as described in Section 148.25(b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for inpatient services occurring on or after July 1, 1998, in accordance with this Section.~~

- a) ~~To qualify for payments under this subsection (a), a hospital must be a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), that was licensed by a municipality on or before December 31, 1997. Hospitals qualifying under this subsection shall receive an adjustment for inpatient services equal to the product of the hospital's psychiatric and physical rehabilitation days, provided to children under 18 years of age during the adjustment base year, multiplied by \$816.00 per~~

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~~day. Payments under this subsection will be based on the following methodology:~~

- ~~1) The calculation under this subsection (a) may not exceed more than 850 days.~~
- ~~2) For the purposes of calculating payments under this subsection (a), the adjustment base year shall be psychiatric and physical rehabilitation days of care provided by the portion of the hospital that the Department does not recognize as a children's hospital. Such days include those provided in State fiscal year 1997 and adjudicated by the Department through March 31, 1998.~~
- ~~b) In addition to the payments described under subsection (a) of this Section, any children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), will receive an additional adjustment equal to the product of the hospital's total paid days, excluding Medicare crossover claims, multiplied by \$113.00 per day. Such days include those provided in State fiscal year 1999 and adjudicated by the Department through May 31, 1999.~~
- ~~e) For rate years occurring after State fiscal year 2000, total payments made under subsections (a) and (b) of this Section shall be paid at least quarterly.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.299 Medicaid Facilitation and Utilization Payments

Medicaid Facilitation and Utilization Payments shall be made on a monthly basis as follows:

- a) **Qualifying Hospitals.** Hospitals may qualify for the Medicaid Facilitation and Utilization Payments if they meet any of the following criteria:
 - 1) The hospital must be an Illinois general acute care hospital that had an increase over 35% of the total Medicaid days, excluding Medicare crossover days, from State fiscal year 2009 to State fiscal year 2013 as recorded in the Department's paid claims data, had more than 50 routine beds as included in the 2012 cost report filed with the Department, and, for State fiscal year 2013, the average length of stay was less than 4.5 days.

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- 2) The hospital must be an Illinois general acute care hospital that had a Medicaid Inpatient Utilization Rate (MIUR), as defined in Section 148.120(i)(4), between 50 and 80 percent, is designated a Perinatal Level II facility, and had less than 110 routine beds as included in the 2012 Cost Report on file with the Department, and, for State fiscal year 2013, provided greater than 6,000 Medicaid days, excluding Medicare crossover days, as recorded in the Department's paid claims database.
 - 3) The hospital must be an Illinois children's hospital, as defined in Section 148.25(d)(3)(B), had greater than 10 routine beds as included in the 2012 cost report on file with the Department, and for State fiscal year 2013, the average length of stay was less than 4.5 days.
- b) Rates
- 1) Hospitals qualifying under subsection (a)(1) will receive the following:
 - A) If the hospital provided more than 4,000 covered Medicaid days, excluding Medicare crossover days in State fiscal year 2013, as recorded in the Department's paid claims database, the rate is \$947.00 for dates of service on July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.
 - B) If the hospital provided less than 4,000 covered Medicaid days, excluding Medicare crossover days, in State fiscal year 2013, as recorded in the Department's paid claims database, the rate is \$76.00 for dates of service on July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.
 - 2) Hospitals qualifying under subsection (a)(2) will receive the following:
 - A) If the hospital had greater than 100 routine beds, as included in the 2012 cost report on file with the Department, the rate is \$205.00 for dates of service on July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.

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- B) If the hospital had less than 100 routine beds, as included in the 2012 cost report on file with the Department, the rate is \$59.00 for dates of service on July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.
- 3) Hospitals qualifying under subsection (a)(3) will receive a rate of \$390.00 for dates of service on July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is \$0.00.
- c) Payment for a qualifying hospital shall be the product of the rate as defined in subsection (b), multiplied by the hospital's SFY 2013 covered days less Medicare crossover days as recorded in the Department's paid claims data (adjudicated through February 21, 2014).

(Source: Added at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.300 Payment

Effective for dates of service on or after July 1, 2014:

- a) The Department will adjust rate methodologies used to reimburse hospitals to assure compliance with applicable aggregate and hospital-specific federal payment limitations.
- b) Effect of Change of Ownership on Payments. When a hospital's ownership changes, payment for hospital services for each patient, including payment adjustments, will be made to the entity that is the legal owner on the date of discharge. Payment will not be prorated between the buyer and seller.
- 1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished regardless of when the client's coverage began or ended during a stay, or how long the stay lasted.
- 2) Each bill submitted must include all information necessary for the Department to compute the payment amount, whether some of the information is attributable to a period during which a different party legally owned the hospital.

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- c) Notwithstanding any other provisions of 89 Ill. Adm. Code 148, 149 or 152, a hospital that is located in a county of the State in which the Department mandates some or all of the 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 Illinois Public Aid Code, shall not be eligible for any non-claims based payments not mandated by Article V-A of the Illinois Public Aid Code that it would otherwise be qualified to receive, unless the hospital is a Coordinated Care Participating Hospital, as defined in Section 148.25(f), 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 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.310 Review Procedure

Effective for dates of service on or after July 1, 2014:

- a) ~~Inpatient~~ Rate Reviews
Hospitals shall be notified of their rates for the rate year and shall have an opportunity to request a review, pursuant to subsection (f), of any rate for errors in calculation made by the Department.
- 1) ~~Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of any rate for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its rates. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~
- 2) ~~Hospitals reimbursed in accordance with Sections 148.250 through 148.300 and 89 Ill. Adm. Code 149 with respect to per diem add-ons for capital may request that an adjustment be made to their base year costs to reflect significant changes in costs that have been mandated in order to meet State, federal or local health and safety standards, and that have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e.,~~

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~~on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be submitted, in writing, to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its rates. Such request shall include a clear explanation of the cost change and documentation of 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.~~

- b) Disproportionate Share Hospital (DSH) and Medicaid Percentage Adjustment (MPA) Determination Reviews
- 1) Hospitals shall be notified of their qualification for DSH ~~and/or~~ MPA payment adjustments and shall have an opportunity to request a review pursuant to subsection (f) of the DSH ~~and/or~~ MPA add-on for errors in calculation made by the Department. ~~Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its disproportionate share and/or Medicaid Percentage Adjustment qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of 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.~~
- 2) DSH ~~and/or~~ MPA determination reviews shall be limited to the following:
- A) DSH ~~and/or~~ MPA Determination Criteria. The criteria for DSH determination shall be in accordance with Section 148.120. The criteria for MPA determination shall be in accordance with Section 148.122. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.
- B) Medicaid Inpatient Utilization Rates.
- i) Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(i)(4)~~148.120(k)(4)~~. Review

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shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

- ii) Hospitals' Medicaid inpatient utilization rates, as defined in Section ~~148.120(i)(4)~~~~148.120(k)(4)~~, which have been derived from unaudited cost reports ~~or HDSC forms~~, are not subject to the Review Procedure with the exception of errors in calculation by the Department. Pursuant to Section 148.120(c)(1)(B) ~~and (e)(1)(C)(i) and (ii)~~, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH ~~and/or~~ MPA determination.
- C) Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act, as defined in Section 148.120(a)(2) ~~and (d), and Section 148.122(a)(2) and (e)~~. Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.
- D) Federally Designated Health Manpower Shortage Areas (HMSAs). Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5 (1989) and Section 148.122(a)(3) based upon the methodologies utilized by, and the most current information available to, the Department from the federal Department of Health and Human Services ~~as of June 30, 1992~~. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HMSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA ~~as of June 30, 1992~~.
- E) Excess Beds. Excess bed information shall be determined in accordance with Public Act 86-268 (Section 148.122(a)(3) and 77 Ill. Adm. Code 1100) based upon the methodologies utilized by, and the most current information available to, the Illinois Health

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Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect.

- F) Medicaid Obstetrical Inpatient Utilization Rates. Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with Section ~~148.122(g)(3)~~148.122(a)(4), (h)(2), (h)(3) and (h)(4). Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations.
- c) **Outlier Adjustment Reviews**
The Department shall make outlier adjustments to payment amounts in accordance with 89 Ill. Adm. Code 149.105 ~~or Section 148.130, whichever is applicable~~. Hospitals shall be notified of the specific information that shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review pursuant to subsection (f) of such specific information for errors in calculation made by the Department. ~~Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of the specific information that shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of 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.~~
- d) **Cost Report Reviews**
Cost report reviews are described in Section 148.210(e). ~~Cost reports are required from:~~
- A) ~~All enrolled hospitals within the State of Illinois;~~
 - B) ~~All out of state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and~~

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- ~~C) All hospitals not located in Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the DRG PPS).~~
- 2) ~~The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days after the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report, which may contain adjustments and revisions that may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis that support the request for review. No additional data shall be accepted after the 45-day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~
- e) ~~Trauma-Center Adjustment Reviews~~
- 1) ~~The Department shall make trauma care adjustments in accordance with Section 148.290(c). Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation by the Department.~~
- 2) ~~Trauma level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating~~

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~~that the information supplied to and utilized by the Department was incorrect.~~

- ~~3) Appeals under this subsection (e) must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of 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.~~

- ef) Medicaid High Volume Adjustment Reviews
The Department shall make Medicaid high volume adjustments in accordance with Section ~~148.112~~148.290(d). Hospitals shall be notified of the Department's determination and have an opportunity to request a review, pursuant to subsection (f). That review~~Review~~ shall be limited to verification that the Medicaid inpatient days were calculated in accordance with Section 148.120. ~~The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of 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.~~

f) Rate Review Requirements

1) Requests for Review

A) All requests for review must be submitted in writing and must either be received by the Department, or post marked within 30 days after the date of the Department's notice to the hospital. The request shall include:

- i) a clear explanation of any suspected error;
ii) any additional documentation to be considered; and

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- iii) the desired corrective action.
- B) The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- 2) The review procedures provided for in this Section may not be used to submit any new or corrected information that was required to be submitted by a specific date in order to qualify for a payment or payment adjustment. In addition, only information that was submitted expressly for the purpose of qualifying for the payment or payment adjustment under review shall be considered by the Department. Information that has been submitted to the Department for other purposes will not be considered during the review process.
- 3) For purposes of this subsection (f), the term "post marked" means the date of processing by the United States Post Office or any independent carrier service.
- g) Sole Community Hospital Designation Reviews
The Department shall make sole community hospital designations in accordance with 89 Ill. Adm. Code 149.125(b). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.
- h) Geographic Designation Reviews
- 1) The Department shall make rural hospital designations in accordance with Section 148.25(g)(3). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the

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~~date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.~~

- 2) ~~The Department shall make urban hospital designations in accordance with Section 148.25(g)(4). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.~~

- i) ~~Critical Hospital Adjustment Payment (CHAP) Reviews~~

- 1) ~~The Department shall make CHAP in accordance with Section 148.295. Hospitals shall be notified in writing of the results of the CHAP determination and calculation, and shall have the right to appeal the CHAP calculation or their ineligibility for the CHAP if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for CHAP and payment adjustment amounts, or a letter of notification that the hospital does not qualify for the CHAP. Such a request shall include a clear explanation of the reason for the appeal and documentation of 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.~~
- 2) ~~CHAP determination reviews shall be limited to the following:~~
 - A) ~~Federally Designated Health Professional Shortage Areas (HPSAs). Illinois hospitals located in federally designated HPSAs shall be identified in accordance with 42 CFR 5, and Section~~

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~~148.295(a)(3)(B) and (b)(3) based upon the methodologies utilized by, and the most current information available to, the Department from the federal Department of Health and Human Services as of the last day of June preceding the CHAP rate period. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HPSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HPSA as of the last day of June preceding the CHAP rate period.~~

- ~~B) Trauma level designation. Trauma level designation is obtained from the Illinois Department of Public Health as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.~~
- ~~C) Accreditation of Rehabilitation Facilities. Accreditation of rehabilitation facilities shall be obtained from the Commission on Accreditation of Rehabilitation Facilities as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Commission, substantiating that the information supplied to and utilized by the Department was incorrect.~~
- ~~D) Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.~~
- ~~E) Graduate Medical Education Programs. Graduate Medical Education program information shall be obtained from the most recently published report of the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American~~

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~~Dental Association Joint Commission on Dental Accreditation as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the above, substantiating that the information supplied to and utilized by the Department was incorrect.~~

- j) ~~Tertiary Care Adjustment Payment Reviews. The Department shall make Tertiary Care Adjustment Payments in accordance with Section 148.296. Hospitals shall be notified in writing of the results of the Tertiary Care Adjustment Payments determination and calculation, and shall have the right to appeal the Tertiary Care Adjustment Payments calculation or their ineligibility for Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Tertiary Care Adjustment 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.~~
- k) ~~Pediatric Outpatient Adjustment Payment Reviews. The Department shall make Pediatric Outpatient Adjustment payments in accordance with Section 148.297. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for payments under Section 148.297 if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification under Section 148.297 and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such 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.~~

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- l) ~~Pediatric Inpatient Adjustment Payment Reviews. The Department shall make Pediatric Inpatient Adjustment payments in accordance with Section 148.298. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for payments under Section 148.298 if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification under Section 148.298 and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such 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.~~
- m) ~~Safety Net Adjustment Payment Reviews. The Department shall make Safety Net Adjustment Payments in accordance with Section 148.126. Hospitals shall be notified in writing of the results of the Safety Net Adjustment Payment determination and calculation, and shall have the right to appeal the Safety Net Adjustment Payment calculation or their ineligibility for Safety Net Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Safety Net Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Safety Net Adjustment 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.~~
- n) ~~Psychiatric Adjustment Payment Reviews. The Department shall make Psychiatric Adjustment Payments in accordance with Section 148.105. Hospitals shall be notified in writing of the results of the Psychiatric Adjustment Payments determination and calculation, and shall have a right to appeal the Psychiatric Adjustment Payments calculation or their ineligibility for Psychiatric Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the~~

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~~Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Adjustment 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.~~

- o) ~~Rural Adjustment Payment Reviews. The Department shall make Rural Adjustment Payments in accordance with Section 148.115.~~
 - 1) ~~Hospitals shall be notified in writing of the results of the Rural Adjustment Payments determination and calculation, and shall have a right to appeal the Rural Adjustment Payments calculation or their ineligibility for Rural Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department.~~
 - 2) ~~The designation of Critical Access Provider or Necessary Provider, which are qualifying criteria for Rural Adjustment Payments (see Section 148.115(a)), is obtained from the Illinois Department of Public Health (IDPH) as of the first day of July preceding the Rural Adjustment Payment rate period. Review shall be limited to requests accompanied by documentation from IDPH, substantiating that the information supplied to and utilized by the Department was incorrect.~~
 - 3) ~~The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rural Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rural Adjustment 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.~~
- p) ~~Supplemental Tertiary Care Adjustment Payment Reviews. The Department shall make Supplemental Tertiary Care Adjustment Payments in accordance with~~

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~~Section 148.85. Hospitals shall be notified in writing of the results of the Supplemental Tertiary Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Tertiary Care Adjustment Payments calculation or their ineligibility for Supplemental Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Tertiary Care Adjustment 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.~~

- q) ~~Medicaid Inpatient Utilization Rate Adjustment Payment Reviews. The Department shall make Medicaid Inpatient Utilization Rate Adjustment Payments in accordance with Section 148.90. Hospitals shall be notified in writing of the results of the Medicaid Inpatient Utilization Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Inpatient Utilization Rate Adjustment Payments calculation or their ineligibility for Medicaid Inpatient Utilization Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Inpatient Utilization Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Inpatient Utilization Rate Adjustment 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.~~
- r) ~~Medicaid Outpatient Utilization Rate Adjustment Payment Reviews. The Department shall make Medicaid Outpatient Utilization Rate Adjustment Payments in accordance with Section 148.95. Hospitals shall be notified in writing of the results of the Medicaid Outpatient Utilization Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal~~

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~~the Medicaid Outpatient Utilization Rate Adjustment Payments calculation or their ineligibility for Medicaid Outpatient Utilization Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Outpatient Utilization Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Outpatient Utilization Rate Adjustment 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.~~

- s) ~~Outpatient Rural Hospital Adjustment Payment Reviews. The Department shall make Outpatient Rural Adjustment Payments in accordance with Section 148.100. Hospitals shall be notified in writing of the results of the Outpatient Rural Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Rural Adjustment Payments calculation or their ineligibility for Outpatient Rural Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Rural Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Rural Adjustment 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.~~
- t) ~~Outpatient Service Adjustment Payment Reviews. The Department shall make Outpatient Service Adjustment Payments in accordance with Section 148.103. Hospitals shall be notified in writing of the results of the Outpatient Service Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Service Adjustment Payments calculation or their ineligibility for Outpatient Service Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the~~

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~~hospital of its qualification for Outpatient Service Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Service Adjustment 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.~~

- u) ~~Psychiatric Base Rate Adjustment Payment Reviews. The Department shall make Psychiatric Base Rate Adjustment Payments in accordance with Section 148.110. Hospitals shall be notified in writing of the results of the Psychiatric Base Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Psychiatric Base Rate Adjustment Payments calculation or their ineligibility for Psychiatric Base Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Base Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Base Rate Adjustment 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.~~
- v) ~~High Volume Adjustment Payment Reviews. The Department shall make High Volume Adjustment Payments in accordance with Section 148.112. Hospitals shall be notified in writing of the results of the High Volume Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the High Volume Adjustment Payments calculation or their ineligibility for High Volume Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for High Volume Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for High Volume Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department~~

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~~shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

- w) ~~Medicaid Eligibility Payment Reviews. The Department shall make Medicaid Eligibility Payments in accordance with Section 148.402. Hospitals shall be notified in writing of the results of the Medicaid Eligibility Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Eligibility Payments calculation or their ineligibility for Medicaid Eligibility Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Eligibility Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Eligibility 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.~~
- x) ~~Medicaid High Volume Adjustment Payment Reviews. The Department shall make Medicaid High Volume Payments in accordance with Section 148.404. Hospitals shall be notified in writing of the results of the Medicaid High Volume Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid High Volume Payments calculation or their ineligibility for Medicaid High Volume Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid High Volume Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid High Volume Adjustment 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.~~
- y) ~~Intensive Care Adjustment Payment Reviews. The Department shall make Intensive Care Payments in accordance with Section 148.406. Hospitals shall be notified in writing of the results of the Intensive Care Payments determination and~~

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~~calculation. Hospitals shall have a right to appeal the Intensive Care Payments calculation or their ineligibility for Intensive Care Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Intensive Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Intensive Care Adjustment 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.~~

- z) ~~Trauma Center Adjustment Payment Reviews. The Department shall make Trauma Center Adjustment Payments in accordance with Section 148.408. Hospitals shall be notified in writing of the results of the Trauma Center Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Trauma Center Adjustment Payments calculation or their ineligibility for Trauma Center Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Trauma Center Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Trauma Center Adjustment 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.~~
- aa) ~~Psychiatric Rate Adjustment Payment Reviews. The Department shall make Psychiatric Rate Adjustment Payments in accordance with Section 148.410. Hospitals shall be notified in writing of the results of the Psychiatric Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Psychiatric Rate Adjustment Payments calculation or their ineligibility for Psychiatric Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Rate Adjustment Payments and payment~~

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~~adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Rate Adjustment 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.~~

- bb) ~~Rehabilitation Adjustment Payment Reviews. The Department shall make Rehabilitation Adjustment Payments in accordance with Section 148.412. Hospitals shall be notified in writing of the results of the Rehabilitation Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Rehabilitation Adjustment Payments calculation or their ineligibility for Rehabilitation Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rehabilitation Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rehabilitation Adjustment 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.~~
- cc) ~~Supplemental Tertiary Care Adjustment Payment Reviews. The Department shall make Supplemental Tertiary Care Adjustment Payments in accordance with Section 148.414. Hospitals shall be notified in writing of the results of the Supplemental Tertiary Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Tertiary Care Adjustment Payments calculation or their ineligibility for Supplemental Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Tertiary Care Adjustment 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.~~

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- dd) ~~Crossover Percentage Adjustment Payment Reviews. The Department shall make Crossover Percentage Adjustment Payments in accordance with Section 148.416. Hospitals shall be notified in writing of the results of the Crossover Percentage Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Crossover Percentage Adjustment Payments calculation or their ineligibility for Crossover Percentage Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Crossover Percentage Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Crossover Percentage Adjustment 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.~~
- ee) ~~Long Term Acute Care Hospital Adjustment Payment Reviews. The Department shall make Long Term Acute Care Hospital Adjustment Payments in accordance with Section 148.418. Hospitals shall be notified in writing of the results of the Long Term Acute Care Hospital Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Long Term Acute Care Hospital Adjustment Payments calculation or their ineligibility for Long Term Acute Care Hospital Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Long Term Acute Care Hospital Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Long Term Acute Care Hospital Adjustment 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.~~
- ff) ~~Obstetrical Care Adjustment Payment Reviews. The Department shall make Obstetrical Care Adjustment Payments in accordance with Section 148.420.~~

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~~Hospitals shall be notified in writing of the results of the Obstetrical Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Obstetrical Care Adjustment Payments calculation or their ineligibility for Obstetrical Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Obstetrical Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Obstetrical Care Adjustment 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.~~

~~gg) Outpatient Access Payment Reviews. The Department shall make Outpatient Access Payments in accordance with Section 148.422. Hospitals shall be notified in writing of the results of the Outpatient Access Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Access Payments calculation or their ineligibility for Outpatient Access Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Access Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Access 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.~~

~~hh) Outpatient Utilization Payment Reviews. The Department shall make Outpatient Utilization Payments in accordance with Section 148.424. Hospitals shall be notified in writing of the results of the Outpatient Utilization Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Utilization Payments calculation or their ineligibility for Outpatient Utilization Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient~~

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~~Utilization Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Utilization 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.~~

- ii) ~~Outpatient Complexity of Care Adjustment Payment Reviews. The Department shall make Outpatient Complexity of Care Adjustment Payments in accordance with Section 148.426. Hospitals shall be notified in writing of the results of the Outpatient Complexity of Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Complexity of Care Adjustment Payments calculation or their ineligibility for Outpatient Complexity of Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Complexity of Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Complexity of Care Adjustment 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.~~

- jj) ~~Rehabilitation Hospital Adjustment Payment Reviews. The Department shall make Rehabilitation Hospital Adjustment Payments in accordance with Section 148.428. Hospitals shall be notified in writing of the results of the Rehabilitation Hospital Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Rehabilitation Hospital Adjustment Payments calculation or their ineligibility for Rehabilitation Hospital Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rehabilitation Hospital Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rehabilitation Hospital Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and~~

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~~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.~~

- ~~kk) Perinatal Outpatient Adjustment Payment Reviews. The Department shall make Perinatal Outpatient Adjustment Payments in accordance with Section 148.430. Hospitals shall be notified in writing of the results of the Perinatal Outpatient Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Perinatal Outpatient Adjustment Payments calculation or their ineligibility for Perinatal Outpatient Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Perinatal Outpatient Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Perinatal Outpatient Adjustment 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.~~
- ~~ll) Supplemental Psychiatric Adjustment Payment Reviews. The Department shall make Supplemental Psychiatric Adjustment Payments in accordance with Section 148.432. Hospitals shall be notified in writing of the results of the Supplemental Psychiatric Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Psychiatric Adjustment Payments calculation or their ineligibility for Supplemental Psychiatric Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Psychiatric Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Psychiatric Adjustment 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.~~

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- ~~mm) Outpatient Community Access Adjustment Payment Reviews. The Department shall make Outpatient Community Access Adjustment Payments in accordance with Section 148.434. Hospitals shall be notified in writing of the results of the Outpatient Community Access Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Community Access Adjustment Payments calculation or their ineligibility for Outpatient Community Access Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Community Access Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Community Access Adjustment 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.~~
- ~~nn) For purposes of this Section, the term "post marked" means the date of processing by the United States Post Office or any independent carrier service.~~
- ~~oo) The review procedures provided for in this Section may not be used to submit any new or corrected information that was required to be submitted by a specific date in order to qualify for a payment or payment adjustment. In addition, only information that was submitted expressly for the purpose of qualifying for the payment or payment adjustment under review shall be considered by the Department. Information that has been submitted to the Department for other purposes will not be considered during the review process.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.320 Alternatives (Repealed)

- ~~a) The provisions of Sections 148.250 through 148.310 of this Part shall be in effect during the fiscal year for so long as the Director of the Department finds that:~~
- ~~1) The total number of hospitals agreeing to be reimbursed pursuant to the provisions of this Part is sufficient to assure that medical assistance~~

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~~recipients have reasonable access to hospital services. In making this determination, factors considered by the Department include but are not limited to service availability and the number of recipients within a geographic area, recipient travel time to obtain services, and availability of a range of services within the geographic area.~~

- ~~2) The provisions are approved by the Department of Health and Human Services in the State Title XIX Plan.~~
 - ~~3) The Department has not been enjoined, restrained or otherwise delayed or prohibited by Court order or actions of entities other than the Department from enforcing the provisions.~~
- b) ~~If any of the conditions specified above fail to occur, alternative service coverage and reimbursement limitations shall be implemented to assure that payments for hospital services during a fiscal year will be approximately the same as would have been made under this Part.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.330 Exemptions

~~Effective for dates of service on or after July 1, 2014, nothing in this Part~~ ~~Nothing in these rules~~ is intended to prevent a hospital from individually negotiating with the Department to set up an alternate methodology for reimbursement that results in an expenditure ~~that~~ ~~which~~ does not exceed the expenditure ~~that~~ ~~which~~ would otherwise be made under this ~~Part~~ ~~rule~~.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.370 Payment for Sub-acute Alcoholism and Substance Abuse Treatment Services

Effective for dates of service on or after July 1, 2014:

- a) The amount approved for payment for sub-acute alcoholism and substance abuse treatment is based on the type and amount of services required by and actually delivered to a recipient. The amount is determined in accordance with prospective rates developed by the Department of Human Services and approved

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and adopted by the Department ~~of Public Aid~~ (see 77 Ill. Adm. Code 2090.70). The adopted rate shall not exceed the charges to the general public.

- b) Rates are generated through the application of formal methodologies specific to each category in accordance with the specifications in 77 Ill. Adm. Code 2090.35, 2090.40 and 2090.70. Rate appeals are allowable pursuant to the specifications in 77 Ill. Adm. Code 2090.80.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.390 HearingsEffective for dates of service on or after July 1, 2014:

- a) The Department may initiate administrative proceedings pursuant to 89 Ill. Adm. Code ~~Part 104.5~~-Subpart C to suspend or terminate certification and eligibility to participate in the Illinois Medical Assistance Program where the provider:
- 1) Has failed to comply with 77 Ill. Adm. Code 2090.40; ~~and/or~~
 - 2) Does not have a valid license for an enrolled treatment service category;
 - 3) Any of the grounds for payment recovery or termination set forth in 89 Ill. Adm. Code 140.15 or 140.16 or 89 Ill. Adm. Code 104.Subpart C are present.
- b) When a proceeding is initiated against providers of alcoholism or substance abuse services, the Department shall notify the provider of the intended ~~actions~~action(s). Notice, service and proof of service shall be in accordance with the "Rules of Practice For Medical Vendor Administrative Proceedings" (89 Ill. Adm. Code 104.5-Subpart C).
- c) All hearings held pursuant to these rules shall be conducted by an attorney designated by the Director of the Department as a hearing officer and said hearing shall be conducted under and governed by the applicable "Rules of Practice For Medical Vendor Administrative Proceedings" promulgated by the Department (89 Ill. Adm. Code 104.5-Subpart C).

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- d) The hearing officer shall prepare a written report of the case which shall contain findings of fact and recommended decisions with regard to the issues of recoupment, certification and continued participation in the Medicaid Program. The ~~Associate~~ Director of the ~~Division~~~~Office~~ of Alcoholism and Substance Abuse (Department of Human Services) ~~may~~~~shall~~ also make a recommendation ~~that final shall be~~ in writing and ~~forward~~~~forwarded~~ to the Director of ~~the Department of IDPA~~. The Director of the Department shall then make a final decision based on the findings of fact and all recommendations. A final administrative decision shall be issued in writing and contain findings of fact and the final determinations concerning recoupment, certification and continued participation in the Medicaid Program. A copy of the decision shall be served on each party.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.400 Special Hospital Reporting Requirements

Corrective Action Plans. ~~Effective for dates of service on or after July 1, 2014,~~ hospitals are responsible for assuring that services provided to ~~Medical Assistance Program~~~~Medicaid program~~ participants meet or exceed the appropriate standards for care. Any provider that is under any corrective action ~~plans~~~~plan(s)~~, while enrolled with the Department, by any licensing, certification and/or accreditation authority, including, but not limited to, the Illinois Department of Public Health, the ~~federal~~~~Federal~~ Department of Health and Human Services, a peer review organization, ~~or TJC and/or the Joint Commission for Accreditation of Health Care Organization~~, must report the request for ~~the~~~~such~~ corrective action plans to the Department. Information submitted will remain confidential.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.436 Long Term Stay Hospital Per Diem Payments

Conversion of Static Payments to Per Diem Payments for Long Term Stay Hospital

- a) Hospitals qualifying as a long term stay hospital on July 1, 2013, as defined at 89 Ill. Adm. Code 149.50(c)(4), shall have their payments paid as a per diem rate add-on for all current claims beginning with admissions on or after November 16, 2013.

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- b) Each long term stay hospital's per diem add-on shall be the sum of its annual payment amounts in accordance with Sections 148.126, 148.295 and 148.296 for State fiscal year 2011, divided by its covered days for dates of service in State fiscal year 2011 as contained in the Department's Medicaid Management Information System (MMIS).
- c) For the payments due and payable in the period beginning July 1, 2013 through November 15, 2013, each long term stay hospital will be paid an annual amount prorated. The prorated amount shall be the product of the sum of the long term stay hospital's annual payment amounts in accordance with Sections 148.126, 148.295 and 148.296 for State fiscal year 2013 multiplied by the quotient resulting from dividing 137 days by 365 days.
- d) [For discharges on or after July 1, 2014, this Section shall no longer be in effect and shall be replaced by 89 Ill. Adm. Code 148.115.](#)

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.442 Inpatient Services Adjustment Payments

- a) **Qualifying criteria.** With the exception of a large public hospital, all Illinois hospitals qualify for the Inpatient Services Adjustment payment.
- b) **Payment.** A hospital shall receive an annual payment that is the sum of the following amounts for which it qualifies:
- 1) A general acute care hospital shall receive an annual amount that is equal to 40% of its base inpatient payments.
 - 2) A freestanding specialty hospital shall receive an annual amount that is equal to 60% of its base inpatient payments.
 - 3) A children's hospital shall receive an annual amount that is equal to 20% of its base inpatient payments.
 - 4) A children's hospital shall receive an annual amount that is equal to 20% of its payments for inpatient psychiatric services provided during State fiscal year 2005.

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- 5) An Illinois hospital licensed by the Illinois Department of Public Health (IDPH) as a psychiatric or rehabilitation hospital shall receive an annual amount that is equal to the product of the following factors:
 - A) Medicaid inpatient days.
 - B) \$1,000.
 - C) The positive percentage of change in the hospital's MIUR between 2005 and 2007.

- 6) A children's hospital shall receive an annual amount that is the product of the annual payment ~~as defined in~~ as defined in Section 148.298 ~~on December 31, 2013, as seen in~~ http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, multiplied by:
 - A) 2.50, for a hospital that is a freestanding children's hospital
 - B) 1.00, for any other hospital.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.446 Obstetrical Care Payments

- a) Qualifying criteria. With the exception of a large public hospital, a general acute care hospital qualifies for the Obstetrical Care payment if the hospital is one of the following:
 - 1) A rural hospital, ~~as defined~~ as being located outside a metropolitan statistical area or located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by DPH and must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993)~~in Section 148.25(g)(3)~~, with a Medicaid obstetrical rate greater than 15%.

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- 2) Classified, on December 31, 2006, as a perinatal level III hospital by IDPH and that had a case mix index equal to or greater than the 45th percentile of such perinatal level III hospitals.
 - 3) Classified, on December 31, 2006, as a perinatal level II or II+ hospital by IDPH and that had a case mix index equal to or greater than the 35th percentile, of such perinatal level II and II+ hospitals combined.
- b) Payment. Qualifying hospitals shall receive an annual payment that is the product of the hospital's Medicaid obstetrical days and:
- 1) \$1,500, for a hospital qualifying under subsection (a)(1) ~~of this Section.~~
 - 2) \$1,350, for a hospital qualifying under subsection (a)(2) ~~of this Section.~~
 - 3) \$900, for a hospital qualifying under subsection (a)(3) ~~of this Section.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.448 Trauma Care Payments

- a) Qualifying criteria. With the exception of a large public hospital, a hospital qualifies for this payment if the hospital is one of the following:
- 1) A general acute care hospital that, as of July 1, 2007, was designated by ~~DPH~~IDPH as a trauma center.
 - 2) A children's hospital, located in a contiguous state, that has been designated a trauma hospital by that State providing more than 8,000 Illinois Medicaid days.
- b) Payment. A hospital shall receive an annual payment that is the sum of the following amounts for which it qualifies:
- 1) The product of the hospital's Medicaid inpatient general acute care days and \$400, for a general acute care hospital designated as a Level II trauma

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center as identified in ~~Section 89 Ill. Adm. Code~~ 148.295(a)(3) and (a)(4) ~~as of December 31, 2013, as seen in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.~~

- 2) The product of the amount of the State fiscal year 2005 Medicaid capital payments and the factor of 3.75, for a general acute care hospital designated as a trauma center as ~~defined~~ ~~identified~~ in ~~Section 89 Ill. Adm. Code~~ 148.295(a) ~~on December 31, 2013, as seen in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.~~
- 3) The product of the hospital's Medicaid general acute care inpatient days and \$235, for a hospital that qualifies under (a)(2) ~~of this Section~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.450 Supplemental Tertiary Care Payments

- a) Qualifying criteria. An Illinois hospital that qualified in ~~SFY State fiscal~~ year 2007 for a payment described in Section 148.296, ~~as in effect on December 31, 2013, as seen in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.~~
- b) Payment. A hospital shall receive an annual payment that is equal to the amount for which it qualified in ~~SFY State fiscal~~ year 2007 in Section 148.296, ~~as was in effect on December 31, 2013, as seen in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.~~

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.456 Ambulatory Procedure Listing Increase Payments

- a) Qualifying criteria. With the exception of a large public hospital, as defined in Section 148.458(a) Ambulatory Procedure Listing Increase payment shall be shall be made to each Illinois hospital.
- b) Payment. Qualifying hospitals shall receive an annual payment that is the sum of:

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- 1) For a hospital that is licensed by the Department of Public Health as a psychiatric specialty hospital, the product of:
 - A) The hospital's payments for type B psychiatric clinic services provided during ~~SFY State fiscal year~~ 2005 that reimbursed through methodologies ~~defined described~~ in ~~Section subsection~~ 148.140(b)(1)(e) ~~on December 31, 2013, as seen in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>~~; and,
 - B) 3.25.
- 2) For all other hospitals:
 - A) The hospital's payments for services provided during ~~SFY State fiscal year~~ 2005 that reimbursed through methodologies ~~defined described~~ in ~~Section Sections~~ 148.140(b)(1)(A) through ~~148.140(b)(1)(D)~~ ~~on December 31, 2013, as seen in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>~~; and,
 - B) 2.20.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

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 ~~SFY 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:

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(+) 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 SFYState 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.

"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 SFYState fiscal-year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 89 Ill. Adm. Code 148.82, by

(ii) the total number of category of service 20 admissions for SFYState fiscal-year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 89 Ill. Adm. Code 148.82.

"Children's hospital" means a hospital as described in 89 Ill. Adm. Code Section 149.50(c)(3).

"Eligibility growth factor" means the percentage by which the number of Medicaid recipients in the county increased from SFYState fiscal-year 1998 to SFYState 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.

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"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 [148.25\(d\)\(4\)](#)~~149.50(e)(4)~~.

"Large public hospital" means a county-owned hospital, as described in Section 148.25~~(a)(b)(1)(A)~~, a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25~~(a)(b)(1)(B)~~, or a hospital owned or operated by a State agency, as described in Section 148.25~~(a)(b)(6)~~.

"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 ~~SFY State fiscal year~~ 2005 as adjudicated by the Department through March 23, 2007.

"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 ~~SFY 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

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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\(i\)\(4\)](#)~~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.
- 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

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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 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.460 Catastrophic Relief Payments (Repealed)

- a) ~~Qualifying Criteria. Catastrophic Relief Payments, as described in this subsection (a), shall be made to Illinois hospitals, except publicly owned or operated hospitals or a hospital identified under 89 Ill. Adm. Code 149.50(e)(3)(B), that have an MIUR greater than the current statewide mean, are not a publicly owned hospital, and are not part of a multiple hospital network, unless the hospital has an MIUR greater than the current statewide mean plus two standard deviations. Payments to qualifying hospitals will be based on the criteria described in this Section.~~
- b) ~~Payments~~
 - 1) ~~An Illinois hospital qualifying under subsection (a) of this Section that is a general acute care hospital with greater than 3,000 Medicaid admissions and a case mix greater than 70% will receive the greater of:~~
 - A) ~~Medicaid admissions multiplied by \$2,250; or~~
 - B) ~~\$8,000,000.~~
 - 2) ~~An Illinois hospital qualifying under subsection (a) of this Section that received payments under Section 148.456 will receive the greater of:~~
 - A) ~~2% of the annual Outpatient Ambulatory Procedure Listing Increase Payments, as defined in Section 148.456; or~~

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- B) ~~\$175,000.~~
- 3) ~~With the exception of psychiatric hospitals, a hospital qualifying under subsection (a) of this Section will receive the following:~~
 - A) ~~\$1,750,000 for Illinois hospitals with more than 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~
 - B) ~~\$1,600,000 for Illinois hospitals with 20 to 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~
 - C) ~~\$750,000 for Illinois hospitals with up to 20 Title XXI admissions in the Catastrophic Relief Payments base period.~~
- 4) ~~A psychiatric hospital qualifying under subsection (a) of this Section will receive the following:~~
 - A) ~~\$1,312,500 for an Illinois hospital with more than 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~
 - B) ~~\$1,200,000 for an Illinois hospital with 20 to 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~
 - C) ~~\$562,500 for an Illinois hospital with up to 20 Title XXI admissions in the Catastrophic Relief Payments base period.~~
- 5) ~~Payments under this Section are effective for State fiscal year 2009. Payments are not effective for dates of service on or after July 1, 2009.~~
- e) ~~Definitions~~
 - 1) ~~"MIUR", for a given hospital, has the meaning ascribed in Section 148.120(i)(4) 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 2009 shall be the same determination used to determine a hospital's eligibility for Catastrophic Relief Payments in the Adjustment Period.~~

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- 2) ~~"General acute care hospital" is a hospital that does not meet the definition of a hospital ascribed in 89 Ill. Adm. Code 149.50(c).~~
- 3) ~~"Title XXI admissions" means recipients of medical assistance through the Illinois State Child Health Plan under Title XXI of the Social Security Act.~~
- 4) ~~"Catastrophic Relief Payments base period" means the 12-month period beginning on July 1, 2006 and ending June 30, 2007.~~
- 5) ~~"Psychiatric hospital" is a hospital as defined in 89 Ill. Adm. Code 149.50(c)(1).~~
- 6) ~~"Case mix index" means, for a given hospital, the quotient resulting from dividing the sum of all the 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 Section 148.82, by the total number of category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82.~~
- 7) ~~"Medicaid admissions" means State fiscal year 2007 hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the 2009 CHAP (Section 148.295) rate period and contained within the Department's paid-claims database, for recipients of medical assistance under Title XIX of the Social Security Act, excluding Medicare/Medicaid crossover admissions.~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.462 Hospital Medicaid Stimulus Payments (Repealed)

~~One-time payments shall be made to all eligible Illinois hospitals, for inpatient and outpatient Medicaid services occurring on or after December 10, 2009, in accordance with this Section. The total payment shall be the sum of the following payment methodologies:~~

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- a) ~~Rural Emergency Services Stimulus Adjustment (RESA)~~
- 1) ~~Qualifying Criteria~~
- A) ~~Rural Illinois hospitals, as defined at 89 Ill. Adm. Code 148.25(g)(3), licensed by the Department of Public Health (IDPH) under the Hospital Licensing Act, certified by IDPH to participate in the Illinois Medicaid Program, and enrolled with the Department of Healthcare and Family Services to participate in the Illinois Medicaid Program; and~~
- B) ~~Provide services as required under 77 Ill. Adm. Code 250.710 in an emergency room subject to the requirements under either 77 Ill. Adm. Code 250.2440(k) or 77 Ill. Adm. Code 250.2630(k).~~
- 2) ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental outpatient payment equal to the hospital's outpatient ambulatory procedure listing payments for Group 3 services, as defined in Section 148.140(b)(1)(C), except that a qualifying hospital designated as a critical access hospital by IDPH in accordance with 42 CFR 485, subpart F (2001) as of July 1, 2009 shall have the payment determined under subsection (a)(2)(A) of this Section multiplied by 3.5, rounded to the nearest whole dollar.~~
- b) ~~Obstetrical Care Severity and Volume Stimulus Adjustment (OCSVSA)~~
- 1) ~~Qualifying Criteria~~
~~With the exception of a large public hospital, a hospital designated as of July 1, 2009 by IDPH as a Perinatal Level III facility in accordance with 77 Ill. Adm. Code 250.1820(f)(1)(C) and that provided more than 2,000 Medicaid obstetrical days.~~
- 2) ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~
- A) ~~The hospital's Medicaid obstetrical days; and~~
- B) ~~\$175.00.~~

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- e) ~~Illinois Trauma Center Stimulus Adjustment (ITCA)~~
- 1) ~~Qualifying Criteria~~
~~With the exception of a large public hospital, a hospital designated as of July 1, 2009 by IDPH as a Level I Trauma Center in accordance with 77 Ill. Adm. Code 515.2030 or 515.2035. For the purposes of this payment, hospitals located in the same city that alternate their Level I Trauma Center designation in accordance with 89 Ill. Adm. Code 148.295(a)(2)(A) shall each be deemed eligible for the payment under this Section.~~
 - 2) ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~
 - A) ~~The hospital's Medicaid inpatient days; and~~
 - B) ~~\$22.00.~~
- d) ~~Acute Care Across the Board Stimulus Adjustment (ABSA)~~
- 1) ~~Qualifying Criteria~~
~~An Illinois hospital, with the exception of a large public hospital and a hospital identified in 89 Ill. Adm. Code 149.50(c)(4).~~
 - 2) ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~
 - A) ~~The hospital's Medicaid inpatient days; and~~
 - B) ~~\$37.00.~~
- e) ~~High Volume Medicaid Dependent Provider Stimulus Adjustment (HVMDA)~~
- 1) ~~Qualifying Criteria~~
~~With the exception of a large public hospital and hospitals identified in 89 Ill. Adm. Code 149.50(c)(1), (c)(2) and (c)(4), an Illinois hospital qualifying for designation under 89 Ill. Adm. Code 148.120 or 148.122 for the rate year beginning October 1, 2009 and ending September 30, 2010.~~

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- 2) ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~
 - A) ~~The hospital's Medicaid inpatient days; and~~
 - B) ~~\$35.00.~~
- f) ~~Adjustments and Limitations~~
 - 1) ~~The provisions of this Section shall be in effect:~~
 - A) ~~Upon approval by the Department of Health and Human Services in the Title XIX State Plan; and~~
 - B) ~~As soon as practicable after the effective date of P.A. 96-821; and~~
 - C) ~~As long as the payments under Sections 148.440 through 148.456 remain eligible for federal match under an approved State Plan Amendment, but not beyond December 31, 2010.~~
 - 2) ~~No hospital shall be eligible for payment under this Section that:~~
 - A) ~~Ceases operations prior to federal approval of, and adoption of, administrative rules necessary to effect payments under this Section; or~~
 - B) ~~Has filed for bankruptcy or is operating under bankruptcy protection under any chapter of USC 11 (Bankruptcy Code); or~~
 - C) ~~Discontinues providing a service recognized by one of the payments for which it qualifies; or~~
 - D) ~~Surrenders a license or designation recognized by one of the payments, or has a designation or certification revoked by the authorizing agency or entity.~~

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- 3) ~~The Department may pay a portion of payments made under this Section in a subsequent State fiscal year to comply with federal law or regulations regarding hospital-specific payment limitations.~~
- g) ~~Definitions. Unless otherwise indicated, the following definitions apply to the terms used in this Section.~~

~~"Hospital" means any facility located in Illinois that is required to submit cost reports as mandated in Section 148.210.~~

~~"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 148.25(b)(6).~~

~~"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.~~

~~"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 day), for admissions occurring during State fiscal year 2005, as adjudicated by the Department through March 23, 2007.~~

~~"Outpatient Ambulatory Procedure Listing Payments" means, for a given hospital, the sum of payments for individuals covered under the Title XIX Medicaid State Plan, for its ambulatory procedure listing Group 3 services as described in Section 148.140(b)(1)(C), 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 March 23, 2007.~~

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- h) [Rate Reviews](#)
~~Rate reviews shall be conducted in accordance with 89 Ill. Adm. Code 148.458(c)(2).~~

(Source: Repealed at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.464 General Provisions

Unless otherwise indicated, the following apply to Sections 148.466 through 148.486.

- a) For any children's hospital that did not charge for its services during the base period, the Department shall use data supplied by the hospital to determine payments using similar methodologies for freestanding children's hospitals under Sections 148.484 and 148.486.
- b) For purposes of this Section, a hospital that is enrolled to provide Medicaid services during ~~SFY State fiscal year~~ 2009 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed.
- c) Payments
- 1) For the period beginning June 10, 2012 through June 30, 2012, the annual payment on services will be prorated by multiplying the payment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days.
 - 2) Effective July 1, 2012, payments shall be paid in 12 equal installments on or before the 7th State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of these payment methodologies or any waiver required under 42 CFR 433.68, at which time the sum of amounts required prior to the date of notification is due and payable.
 - 3) Payments are not due and payable until these payment methodologies are approved by the federal Government and the assessment imposed under Section 5A-2(b-5) of the Public Aid Code, as implemented by 89 Ill. Adm.

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Code 140.80(b)(2), is determined to be a permissible tax under Title XIX of the Social Security Act.

- 4) Accelerated Schedule. The Department may, when practicable, accelerate the schedule upon which payments authorized under Sections 148.466 through 148.486 are made.
- 5) The Department may, in accordance with the IAPA, adjust payments under Sections 148.466 through 148.486 to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.
- 6) If the federal Centers for Medicare and Medicaid Services find that any federal Upper Payment Limit applicable to the payments under Sections 148.466 through 148.486 is exceeded, then the payments under Sections 148.466 through 148.486 that exceed the applicable federal Upper Payment Limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

d) Definitions

Unless the context requires otherwise or unless provided otherwise in Sections 148.466 through 148.486, the terms used in Section 148.484 for qualifying criteria and payment calculations shall have the same meanings as those terms are given in this Part as in effect on October 1, 2011. Other terms shall be defined as indicated in this subsection (d).

"Medicaid Days", "Ambulatory Procedure Listing Services" and "Ambulatory Procedure Listing Payments" do not include any days, charges or services for which Medicare or a Managed Care Organization reimbursed on a capitated basis was liable for payment, except as explicitly stated otherwise in Sections 148.466 through 148.486.

"Ambulatory Procedure Listing Services" means, for a given hospital, ambulatory procedure listing services, as described in Section 148.140(b), [as in effect on June 30, 2009](#), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services

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occurring in ~~SFYState fiscal year~~ 2009 that were adjudicated by the Department through September 2, 2010.

"Case Mix Index" means, for a given hospital, the sum of the per admission (DRG) relative weighting factors in effect on January 1, 2005, for all general acute care admissions for ~~SFYState fiscal year~~ 2009, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82, as in effect on December 31, 2013, as seen in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>, divided by the total number of general acute care admissions for ~~SFYState fiscal year~~ 2009, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82, as was in effect on December 31, 2013, as seen in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.

"Emergency Room Ratio" means, for a given hospital, a fraction, the denominator of which is the number of the hospital's outpatient ambulatory procedure listing and end-stage renal disease treatment services provided for ~~SFYState fiscal year~~ 2009 and the numerator of which is the hospital's outpatient ambulatory procedure listing services for categories 3A, 3B and 3C for ~~SFYState fiscal year~~ 2009.

"Estimated Medicaid Inpatient Days" means a percentage of actual inpatient Medicaid days to total inpatient days for the period July 1, 2011 to June 30, 2012, applied to total actual inpatient days for ~~SFYState fiscal year~~ 2005.

"Estimated Medicaid Outpatient Services" means the percentage of actual outpatient Medicaid services to total outpatient services for the period of July 1, 2011 through June 30, 2012, applied to total actual outpatient services for ~~SFYState fiscal~~ year 2005.

"Large Public Hospital" means ~~a county-owned~~ hospital, as described in Section 148.25 ~~(a)(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 148.25(b)(6).~~

"Medicaid Inpatient Day" means, for a given hospital, the sum of days of inpatient hospital days 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

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tabulated from the Department's paid claims data for admissions occurring during ~~SFY State fiscal year~~ 2009 that were adjudicated by the Department through June 30, 2010.

"Medicaid General Acute Care Inpatient Day" means, a Medicaid inpatient day, as described in this subsection (d), for general acute care hospitals, and specifically excludes days provided in the hospital's psychiatric or rehabilitation units.

"Outpatient End-Stage Renal Disease Treatment Services" means, for a given hospital, the services, as described in Section 148.140(g)(e), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding payments for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services occurring in ~~SFY State fiscal year~~ 2009 that were adjudicated by the Department through September 2, 2010.

e) Rate Reviews

- 1) A hospital shall be notified in writing of the results of the payment determination pursuant to Sections 148.466 through 148.486.
- 2) Hospitals shall have a right to appeal the calculation of their ineligibility for payments 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 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.468 Trauma Level II Hospital Adjustment Payments

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- a) **Qualifying Criteria.** With the exception of a large public hospital, an Illinois general acute care hospital shall qualify for the Trauma Level II Payment if it was designated as a Level II trauma center as of July 1, 2011.
- b) **Payment.** A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid general acute care inpatient days and:
 - 1) \$470, for hospitals with a case mix index equal to or greater than the 50th percentile of case mix indices for all Illinois hospitals.
 - 2) \$170, for all other hospitals.
- c) For the purposes of this adjustment, hospitals located in the same city that alternate their trauma center designation as defined in Section 148.295(a)(2) [on December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx](http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx), shall have the adjustment provided under this Section divided between the two hospitals.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

Section 148.482 Physician Supplemental Adjustment Payments

- a) **Qualifying Criteria.** With the exception of a large public hospital, physician services eligible for this Physician Supplemental Adjustment Payment are those provided by physicians employed by or who have a contract to provide services to patients of the following hospitals:
 - 1) Illinois general acute care hospitals that:
 - A) Provided at least 17,000 Medicaid inpatient days of care in State fiscal year 2009; and
 - B) Was eligible for Medicaid Percentage Adjustment Payments in rate year 2011.
 - 2) Illinois freestanding children's hospitals, as defined in [Section 148.2589 Ill. Adm. Code 149.50\(e\)\(3\)\(A\)](#).

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- b) Payment. A qualifying hospital shall receive an annual payment based upon a total pool of \$6,960,000. This pool shall be allocated among the eligible hospitals based on the following:
- 1) The difference between the upper payment limit for what could have been paid under Medicaid for physician services provided during State fiscal year 2009 by physicians employed by, or who had a contract with, the hospital, and the amount that was paid under Medicaid for those services.
 - 2) In no event shall an individual hospital receive an annual, aggregate adjustment amount on physician services in excess of \$435,000, except that any amount that is not distributed to a hospital because of the upper payment limit shall be reallocated among the remaining eligible hospitals that are below the upper payment limit on a proportionate basis.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

SUBPART F: EMERGENCY PSYCHIATRIC DEMONSTRATION PROGRAM

Section 148.860 Community Connect IMD Hospital Payment

[Effective for dates of service on or after July 1, 2014:](#)

- a) The Community Connect IMD hospital in the demonstration program will be reimbursed on an incentive-driven basis. The Department will reimburse the initial claim for the psychiatric admission at 80% of the psychiatric hospital rate. The remainder of the full 100% of the psychiatric hospital rate will be paid if the individual remains stable in the community with no further psychiatric hospitalization for 45 days after the level of care assessment.
- b) Payment for any individual who cannot be discharged because the individual does not have a place to go and appropriate services cannot be implemented, but who is not an inpatient based on medical necessity, will be 50% of the alternate cost per diem rate as ~~defined~~described in Section 148.270 and 89 Ill. Adm. Code 152.200 on July 1, 2012.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

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Section 148. TABLE C List of Metropolitan Counties by SMSA Definition

"SMSA" means [Standard State Metropolitan Statistical Area as defined by the U.S. Office of Management and Budget \(OMB\) Areas](#).

Boone	Champaign	Clinton	Cook	DuPage
Henry	Kane	Kankakee	Lake	Macon
Madison	McHenry	McLean	Menard	Monroe
Peoria	Rock Island	Sangamon	St. Clair	Tazewell
Will	Winnebago	Woodford		

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)

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- 1) Heading of the Part: Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
- 2) Code Citation: 89 Ill. Adm. Code 149
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
149.5	Repeal
149.10	Amendment
149.25	Amendment
149.50	Amendment
149.75	Amendment
149.100	Amendment
149.105	Amendment
149.125	Repeal
149.150	Repeal
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Rule: July 2, 2014
- 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, 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 21, 2014; 38 Ill. Reg. 4932
- 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 149.10 of Part 149 deleted "Effective for dates of service on or after July 1, 2014" and added "Effective for dates of discharge on or after July 1, 2014".

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In Section 149.25 of Part 149 deleted "Effective for dates of service on or after July 1, 2014" and added "Effective for dates of discharge on or after July 1, 2014".

In subsection 149.25(a)(1)(B) of Section 149.25 deleted "and 149.125".

In subsection 149.25(a)(2)(A) of Section 149.25 deleted "(as described in subsection (a)(3))".

In Section 149.50 of Part 149 deleted "Effective for dates of service on or after July 1, 2014" and added "Effective for dates of discharge on or after July 1, 2014".

In subsection 149.50(b) of Section 149.50 added "(b)(9)" to read as follows: "Inpatient services provided by non-cost reporting hospitals, which will be reimbursed at a rate of \$672.24 per day."

In Section 149.75 of Part 149 deleted "Effective for dates of service on or after July 1, 2014" and added "Effective for dates of discharge on or after July 1, 2014".

In Section 149.100 of Part 149 deleted "Effective for dates of service on or after July 1, 2014" and added "Effective for dates of discharge on or after July 1, 2014".

In subsection 149.100(e)(1) of Section 149.100 changed language to read as follows: "For Medicare IPPS hospitals that are in-state or are out-of-state Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system post-reclass wage index effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the wage index is based on the Medicare IPPS hospital post-reclass wage index effective October 1, 2012."

In subsection 149.100(e)(2) of Section 149.100 changed language to read as follows: "For in-state non-Medicare IPPS hospitals and out-of-state non-Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the wage index is based on the Medicare IPPS wage index for the hospital's Medicare CBSA effective October 1, 2012."

In subsection 149.100(f) of Section 149.100 added a new subsection "(f)(4)" to read as follows:

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- "4) Safety Net
- A) Policy adjustment factor: \$57.50 per general acute care day
 - B) Qualifying criteria: safety-net hospital defined in 305 ILCS 5/5-5e.1 excluding pediatric hospitals as defined in 148.25(d)(3)
 - C) Effective: for dates of service on July 1, 2014 through June 30, 2018."

In subsection 149.100(h) of Section 149.100 added language to the end of the subsection to read as follows: "Groupers shall be updated at least triennially and no more frequently than annually."

In subsection 149.100(i) of Section 149.100 the definition of "Allocated static payments" is changed to read as follows: ""Allocated static payments" means the adjustment payments made to the hospital pursuant to 89 Ill. Adm. Code 148.105, 148.115, 148.126, 148.295, 148.296 and 148.298 during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies outlined in rule as of February 21, 2014 (see <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>), as determined by the Department, allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data."

In subsection 149.100(i) of Section 149.100 the definition of "GME factor" is changed to read as follows: ""GME factor" means the Graduate Medical Education factor applied to major teaching hospitals, as defined in 89 Ill. Adm. Code 148.25(h). Simulated payments under the new inpatient system with GME factor adjustments shall be \$3 million greater than simulated payments under the new inpatient system would have been without the GME factor adjustments, using inpatient base period paid claims data."

In Section 149.105 of Part 149 deleted "Effective for dates of service on or after July 1, 2014" and added "Effective for dates of discharge on or after July 1, 2014".

In subsection 149.105(b)(2) of Section 149.105 deleted "and non-cost reporting hospitals located in an urban Medicare CSBA".

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In subsection 149.105(c)(1) and 149.105(c)(2) of Section 149.105 deleted all language that read as follows:

- 1) Inpatient psychiatric, rehabilitation and long-term acute care services excluded from the DRG PPS pursuant to Section 149.50(b). If the hospital charges, as adjusted by the method specified in subsection (c)(3), exceed the applicable threshold criterion, the Department will make an additional payment to the hospital to cover those costs. A special request or submission is not necessary to initiate this payment.
- 2) Claims for which Medicare is the primary payer. The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost-to-charge ratio as described in subsection (c)(3), subject to the limitations described in subsections (c)(4) and (e) of this Section.

In subsection 149.105(c) of Part 149.105 changed the language to read as follows: "Exclusions. No outlier adjustment shall be paid on claims that are excluded from the DRG PPS pursuant to Section 149.50(b)."

In subsection 149.105(e) of Section 149.105 changed the language to read as follows: "'Fixed loss threshold" means the Medicare fixed loss threshold in effect on October 1, 2012. The Department is authorized to update the "fixed loss threshold". Base rates must be updated within 12 months after the update."

- 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 rule currently in effect? No
- 14) Are there any other rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.
- 16) Information and questions regarding this adopted rule shall be directed to:

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Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd 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~~PUBLIC AID~~
SUBCHAPTER d: MEDICAL PROGRAMS

PART 149

DIAGNOSIS RELATED GROUPING (DRG) PROSPECTIVE PAYMENT SYSTEM (PPS)

Section

- 149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
(Repealed)
- 149.10 Applicability of Other Provisions
- 149.25 General Provisions
- 149.50 Hospital Inpatient Services Subject to and Excluded from the DRG Prospective Payment System
- 149.75 Conditions for Payment Under the DRG Prospective Payment System
- 149.100 ~~Basic~~ Methodology for Determining DRG ~~PPS~~Prospective Payment Rates
- 149.105 Payment For Outlier Cases
- 149.125 Special Treatment of Certain Facilities (Repealed)
- 149.140 Methodology for Determining Primary Care Access Health Care Education Payments (Repealed)
- 149.150 Payments to Hospitals Under the DRG Prospective Payment System (Repealed)
- 149.175 Payments to Contracting Hospitals (Repealed)
- 149.200 Admitting and Clinical Privileges (Repealed)
- 149.205 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Repealed)
- 149.225 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Repealed)
- 149.250 Contract Monitoring (Repealed)
- 149.275 Transfer of Recipients (Repealed)
- 149.300 Validity of Contracts (Repealed)
- 149.305 Termination of ICARE Contracts (Repealed)
- 149.325 Hospital Services Procurement Advisory Board (Repealed)

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

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SOURCE: Recodified from 89 Ill. Adm. Code 140.940 through 140.972 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 12095, effective July 15, 1988; amended at 13 Ill. Reg. 554, effective January 1, 1989; amended at 13 Ill. Reg. 15070, effective September 15, 1989; amended at 15 Ill. Reg. 1826, effective January 28, 1991; emergency amendment at 15 Ill. Reg. 16308, effective November 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 6195, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11937, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14733, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19868, effective December 7, 1992; amended at 17 Ill. Reg. 3217, effective March 1, 1993; emergency amendment at 17 Ill. Reg. 17275, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3378, effective February 25, 1994; amended at 19 Ill. Reg. 10674, effective July 1, 1995; amended at 21 Ill. Reg. 2238, effective February 3, 1997; emergency amendment at 22 Ill. Reg. 13064, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19866, effective October 30, 1998; amended at 25 Ill. Reg. 8775, effective July 1, 2001; amended at 26 Ill. Reg. 13676, effective September 3, 2002; emergency amendment at 27 Ill. Reg. 11080, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18872, effective November 26, 2003; amended at 28 Ill. Reg. 2836, effective February 1, 2004; amended at 38 Ill. Reg. 15477, effective July 2, 2014.

Section 149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
(Repealed)

- a) ~~Sections 149.25 through 149.150 describe:~~
- ~~1) The basis of payment for inpatient hospital services under the DRG PPS and set forth the general basis for the system;~~
 - ~~2) Classifications of hospitals that are included and excluded from the DRG PPS and the requirements governing inclusion or exclusion of hospitals in the system as a result of changes in their classification;~~
 - ~~3) Conditions that must be met for a hospital to receive payment under the DRG PPS;~~
 - ~~4) The methodology by which DRG prospective rates are determined;~~
 - ~~5) The methodology for determining additional payments for outlier cases;~~

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- ~~6) The rules for special treatment of certain facilities; and~~
- ~~7) The types, amounts and methods of payment to hospitals under the DRG PPS.~~
- b) Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992, through March 31, 1994, shall be as follows:
 - 1) ~~Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the base inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under Part 149.~~
 - 2) ~~Exceptions. The provisions of subsection (b)(1) above shall not apply to:~~
 - A) ~~Hospitals reimbursed under 89 Ill. Adm. Code 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.82, 148.160, or 148.170, as applicable.~~
 - B) ~~Hospitals reclassified as rural hospitals as described in 89 Ill. Adm. Code 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.40(f)(4) and 148.260, or Section 149.100(c)(1)(A), whichever is applicable.~~
 - C) ~~The inpatient payment adjustments described in 89 Ill. Adm. Code 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with 89 Ill. Adm. Code 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1) above.~~
- e) **Definitions**
Unless specifically stated otherwise, the definitions of terms used in this Part are as follows:

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- 1) ~~"DRG grouper" means:~~
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare DRG grouper in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).~~
 - B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare DRG grouper which is in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).~~
- 2) ~~"Medicare weighting factor" means:~~
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Medicare DRG weighting factors in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).~~
 - B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Medicare DRG weighting factors in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).~~
- 3) ~~"PPS Pricer" means:~~
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare PPS Pricer, Version 92.0.~~
 - B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare PPS Pricer version that is in effect 90 days prior to the date of admission.~~
- 4) ~~"Marginal Cost Factor":~~
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A),~~

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~~the marginal cost factor shall be the same as that employed by Medicare on September 1, 1992.~~

B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the marginal cost factor shall be the same as that employed by Medicare 90 days prior to the date of admission.~~

5) ~~"Cost Outlier Threshold":~~

A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the cost outlier threshold shall be the same as that employed by Medicare on September 1, 1992, adjusted for the differences in Medicare and Medicaid policies and population, as described in Section 149.100(a)(1).~~

B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the cost outlier threshold/fixed loss threshold shall be the same as that employed by Medicare 90 days prior to the date of admission.~~

(Source: Repealed at 38 Ill. Reg. 15477, effective July 2, 2014)

Section 149.10 Applicability of Other Provisions

Effective for dates of discharge on or after July 1, 2014, theThe following provisions, in addition to those provisions specifically cited in this Part, shall apply to hospitals reimbursed under the Diagnosis Related Grouping Prospective Payment System (DRG PPS):

- a) The general requirements applicable to all hospital services, as described in General Provisions of 89 Ill. Adm. Code 148, Subpart A.~~Participation, as described in 89 Ill. Adm. Code 148.20.~~
- b) Organ transplant services, as described in 89 Ill. Adm. Code 148.82~~Definitions and Applicability, as described in 89 Ill. Adm. Code 148.25.~~
- e) ~~General requirements, as described in 89 Ill. Adm. Code 148.30.~~
- d) ~~Special requirements, as described in 89 Ill. Adm. Code 148.40.~~

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- e) ~~Covered hospital services, as described in 89 Ill. Adm. Code 148.50.~~
- f) ~~Services not covered as hospital services, as described in 89 Ill. Adm. Code 148.60.~~
- g) ~~Limitations on hospital services, as described in 89 Ill. Adm. Code 148.70.~~
- ch) Hospital outpatient and hospital-based clinic services, as described in 89 Ill. Adm. Code 148.140.
- di) Payment for pre-operative days and; patient specific orders, ~~and services which can be performed in an outpatient setting~~, as described in 89 Ill. Adm. Code 148.180.
- ej) Copayments, as described in 89 Ill. Adm. Code 148.190.
- fk) Filing cost reports, as described in 89 Ill. Adm. Code 148.210.
- gl) Review procedure, as described in 89 Ill. Adm. Code 148.310.

(Source: Amended at 38 Ill. Reg. 15477, effective July 2, 2014)

Section 149.25 General ProvisionsEffective for dates of discharge on or after July 1, 2014:

- a) Basis of Payment
 - 1) Payment on a Per Discharge Basis
 - A) Under the DRG PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.
 - B) The DRG prospective payment rate for each discharge (as defined in subsection (b) ~~below~~) is determined according to the methodology described in Sections 149.100 and 149.150, as

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appropriate. An additional payment is made, in accordance with ~~Section~~Sections 149.105 ~~and 149.125~~, as appropriate. The rates paid shall be those in effect on the date of admission.

- 2) Payment in Full
 - A) The DRG prospective payment amount paid for inpatient hospital services is the total Medicaid payment for the inpatient operating costs ~~(as described in subsection (a)(3) below)~~ incurred in furnishing services covered under the Medicaid Program.
 - B) Except as provided for in ~~Section~~subsection 149.100(g), ~~(b) below~~, the full DRG prospective payment amount, as determined under ~~Section~~Sections 149.100 ~~and 149.150~~, as appropriate, is made for each inpatient stay during which there is at least one Medicaid eligible day of care.
- 3) ~~Inpatient Operating Costs. The DRG PPS provides a payment amount for inpatient operating costs, including:~~
 - A) ~~Operating costs for routine services (as described in 42 CFR 413.53(b), revised as of September 1, 1990), such as the costs of room, board, and routine nursing services;~~
 - B) ~~Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;~~
 - C) ~~Special care unit operating costs (intensive care type unit services as described in 42 CFR 413.53(b), revised as of September 1, 1990);~~
 - D) ~~Malpractice insurance costs related to services furnished to inpatients; and~~
 - E) ~~Hospital-based physician costs as described in Section 149.75(h)(1)(A).~~
- 4) ~~Excluded Costs/Services. The following inpatient hospital costs are~~

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~~excluded from the DRG prospective payment amounts:~~

- ~~A) Transplantation cost, including acquisition cost incurred by approved transplantation centers as described in 89 Ill. Adm. Code 148.82. Kidney and cornea transplant costs shall be reimbursed under the appropriate methodology described in Sections 149.100 and 149.150 or in 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.~~
 - ~~B) Costs of psychiatric services incurred by a provider enrolled with the Department to provide those services (category of service 21). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).~~
 - ~~C) Costs of nonemergency psychiatric services incurred by a provider that is not enrolled with the Department to provide those services (category of service 21). Such services shall not be eligible for reimbursement.~~
 - ~~D) Costs of emergency psychiatric services exceeding the maximum of three days emergency treatment incurred by a provider that is not enrolled with the Department to provide those services (DRGs 424-432). Such services exceeding the maximum of three days shall not be eligible for reimbursement.~~
 - ~~E) Costs of physical rehabilitation services incurred by a provider enrolled with the Department to provide those services (category of service 22). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).~~
 - ~~F) Costs of rehabilitation for drug and alcohol abuse (DRG 436 and that part of DRG 437 apportioned to rehabilitation). Such services shall be reimbursed under 89 Ill. Adm. Code 148.340 through 148.390.~~
- 5) Additional Payments to Hospitals. In addition to payments based on the DRG prospective payment rates, hospitals will receive payments for the following:

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- A) ~~Atypically long or extraordinary costly (outlier) cases, as described in Section 149.105.~~
 - B) ~~Certain costs excluded from the prospective payment rate under subsection (a)(4) above.~~
 - C) ~~The cost of serving a disproportionately high share of low income patients (as defined and determined in Section 149.125(a)(2)).~~
 - D) ~~Specific inpatient payment adjustments (as defined and determined in Section 149.125(a)(3)).~~
- b) ~~Discharges and Transfers~~
- 1) ~~Discharges. A hospital inpatient is considered discharged when any of the following occurs:~~
 - A) ~~The patient is formally released from the hospital except when the patient is transferred to another hospital or a distinct part unit as described in Section 149.50(d) (see subsection (b)(2) below).~~
 - B) ~~The patient dies in the hospital.~~
 - 2) ~~Transfers. A hospital inpatient is considered transferred when the patient is placed in the care of another hospital or a distinct part unit as described in Section 149.50(d).~~
 - 3) ~~Payment in Full to the Discharging Hospital. The hospital discharging an inpatient (subsection (b)(1)(A) above) is paid in full, in accordance with subsection (a)(2) above unless the discharging hospital or distinct part unit is excluded from the DRG PPS as described in Section 149.50(b), (c) and (d). In the event the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS, that hospital or distinct part unit shall receive payment in full in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.~~
 - 4) ~~Payment to a Hospital Transferring an Inpatient to Another Hospital or~~

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~~District Part Unit~~

- ~~A) A hospital reimbursed under the DRG PPS that transfers an inpatient, under the circumstances described in subsection (b)(2), is paid a per diem rate for each day of the patient's stay in that hospital but the total reimbursement shall not exceed the amount that would have been paid under Section 149.100 if the patient had been discharged. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under Section 149.100) by the geometric length of stay for the specific DRG to which the case is classified.~~
- ~~B) Except, if a discharge is classified into DRGs 385 or 985 (neonates, died or transferred to another acute care facility) or DRG 456 (burns, transferred to another acute care facility), and the hospital is reimbursed under the DRG PPS, the transferring hospital is paid in accordance with subsection (a)(2).~~
- ~~C) A transferring hospital reimbursed under the DRG PPS may qualify for an additional payment for extraordinarily high cost cases that meet the criteria for cost outliers as described in Section 149.105.~~
- ~~D) A hospital or distinct part unit excluded from the DRG PPS, as described in Section 149.50(b), (c) or (d), that transfers an inpatient under the circumstances described in subsection (b)(2) of this Section, is reimbursed in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.~~
- e) Admission Prior to September 1, 1991. With respect to admissions prior to September 1, 1991, hospitals will receive their per diem reimbursement rate that was in effect July 1, 1991, for each covered day of care provided through the discharge of the patient.
- d) DRG Classification System
- 1) The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), modified to handle additional DRGs and revised ICD-9 CM

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~~codes, as defined by the Department, to place claims into DRG payment classifications.~~

- 2) ~~The Department will define additional DRGs that, for hospitals designated as Level III perinatal centers by the Illinois Department of Public Health, replace DRG 385 (neonates, died or transferred to another acute care facility), DRG 386 (extreme immaturity or respiratory distress syndrome, neonate), DRG 387 (prematurity with major problems) and DRG 389 (full term neonate with major problems).~~

(Source: Amended at 38 Ill. Reg. 15477, effective July 2, 2014)

Section 149.50 Hospital Inpatient Services Subject to and Excluded from the DRG Prospective Payment System

Effective for dates of discharge on or after July 1, 2014:

- a) Inpatient Services Subject to Submission for DRG Grouping. All hospital inpatient services provided to enrollees of the Medical Assistance programs, without regard to balance due or expected reimbursement methodology to be applied by the Department, must be documented on a claim and submitted to the Department. The Department shall process and group all hospital inpatient claims through the DRG grouper.~~Hospital Services Subject to the DRG Prospective Payment System~~
 - 1) ~~Except for services described in Section 149.25(a)(4) and subsection (b)(2) below, all covered inpatient hospital services furnished to persons receiving coverage under the Medicaid Program are paid for under the DRG PPS.~~
 - 2) ~~Inpatient hospital services will not be paid for under the DRG PPS under any of the following circumstances:~~
 - A) ~~The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the DRG PPS under subsections (c) through (d) below.~~
 - B) ~~The services are furnished by a nonparticipating out-of-state~~

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~~hospital (as described in subsection (c)(5) below).~~

- ~~C) The services are furnished by a hospital that elects to be reimbursed under special arrangements (as described in subsection (c)(6) below) in the transition period of DRG PPS implementation.~~
 - ~~D) The services are furnished by a sole community hospital (as defined in Section 149.125(b)) that has elected to be exempted from the DRG PPS in accordance with subsection (c)(7) below.~~
 - ~~E) The payment for services is covered by a health maintenance organization (HMO).~~
- b) Excluded from DRG PPS reimbursements are: ~~and Exempted Hospitals and Hospital Units: General Rules~~
- 1) Psychiatric services provided by: ~~Criteria. A hospital will be excluded from the DRG PPS if it meets the criteria for one or more of the classifications described in subsection (c) below.~~
 - A) A psychiatric hospital, as described in 89 Ill. Adm. Code 148.25(d)(1).
 - B) A distinct part psychiatric unit, as described in 89 Ill. Adm. Code 148.25(c)(1).
 - 2) Physical rehabilitation services provided by: ~~Alternate Reimbursement System. All excluded hospitals (and excluded distinct part hospital units, as described in subsection (d) below) are reimbursed under the Alternate Reimbursement Systems set forth in 89 Ill. Adm. Code 148.250 through 148.300 with the exception of those hospitals described in subsection (c)(8) below. The hospitals described in subsection (c)(8) below are reimbursed in accordance with 89 Ill. Adm. Code 148.160 or 148.170, as appropriate.~~
 - A) A rehabilitation hospital, as described in 89 Ill. Adm. Code 148.25(d)(2).

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- B) A distinct part rehabilitation unit, as described in 89 Ill. Adm. Code 148.25(c)(2).
 - 3) Services provided by a long term acute care hospital, as described in 89 Ill. Adm. Code 148.25(d)(4), that are not psychiatric services or services described in subsections (b)(6) through (b)(7).
 - 4) Inpatient services, reimbursed pursuant to 89 Ill. Adm. Code 148.330.
 - 5) Services provided by a large public hospital, as described in 89 Ill. Adm. Code 148.25(a).
 - 6) Hospital residing long term care services, as described in 89 Ill. Adm. Code 148.50(c).
 - 7) Sub-acute alcoholism and substance abuse treatment services, as defined in 77 Ill. Adm. Code 2090.40.
 - 8) Inpatient services provided by Children's Specialty Hospitals as described in 89 Ill. Adm. Code 148.116.
 - 9) Inpatient services provided by non-cost reporting hospitals, which will be reimbursed at a rate of \$672.24 per day.
- e) ~~Excluded Hospitals: Classifications. Hospitals that meet the requirements for the classifications set forth in this Section may not be reimbursed under the DRG Prospective Payment System.~~
- 1) ~~Psychiatric Hospitals. A psychiatric hospital must:~~
 - A) ~~Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and~~
 - B) ~~Be enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 21) and have a Provider Agreement to participate in the Medicaid Program.~~

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- 2) ~~Rehabilitation Hospitals. A rehabilitation hospital must:~~
- A) ~~Hold a valid license as a physical rehabilitation hospital; and~~
 - B) ~~Be enrolled with the Department as a rehabilitation hospital to provide inpatient rehabilitation services (category of service 22) and have a Provider Agreement to participate in the Medicaid Program.~~
- 3) ~~Children's Hospitals. To qualify as a children's hospital, the facility must have a Provider Agreement to participate in the Medicaid program and be either:~~
- A) ~~A hospital devoted exclusively to caring for children; or~~
 - B) ~~A general care hospital which includes a facility devoted exclusively to caring for children that meets one of the following definitions:~~
 - i) ~~A facility that is separately licensed as a hospital by a municipality prior to September 30, 1998. Such hospitals shall be reimbursed for all inpatient and outpatient services rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation, regardless of the physical location within the hospital complex where the care is rendered; or~~
 - ii) ~~A facility that has been designated by the State as a Level III perinatal care facility, has a Medicaid Inpatient Utilization Rate, as defined at 89 Ill. Adm. Code 148.12(k)(5), greater than 55 percent for the rate year 2003 disproportionate share determination, and has more than 10,000 qualified children days. Qualified children days means the number of hospital inpatient days for recipients under 18 years of age who are eligible under Medicaid, excluding days for normal newborn, obstetrical, psychiatric, Medicare crossover, and rehabilitation services, as determined from the Department's claims data for days~~

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~~occurring in State fiscal year 2001 that were adjudicated by the Department through June 30, 2002. Such hospitals shall be reimbursed for all inpatient and outpatient services rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation, regardless of the physical location within the hospital complex where the care is rendered.~~

- 4) ~~Long Term Stay Hospitals. A long term stay hospital must:~~
 - A) ~~Not be a psychiatric hospital, as described in subsection (c)(1) above, a rehabilitation hospital as described in subsection (c)(2) above, or a children's hospital as described in subsection (c)(3) above and must have an average length of inpatient stay greater than 25 days: as computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the most recent State fiscal year for which complete information is available; and~~
 - B) ~~Have a Provider Agreement to participate in the Medicaid Program.~~
- 5) ~~Hospitals Outside of Illinois that are Exempt from Cost Reporting Requirements. A hospital is excluded from the DRG PPS if it meets the following definition: a nonparticipating out-of-state hospital is an out-of-state hospital that provides fewer than 100 Illinois Medicaid days annually, that does not elect to be reimbursed under this Part (the DRG Prospective Payment System), and that does not file an Illinois Medicaid cost report.~~
- 6) ~~Hospitals Reimbursed Under Special Arrangements. Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in 89 Ill. Adm. Code 148.40(f) through 148.40(h).~~

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- 7) ~~Sole Community Hospitals. Hospitals described in Section 149.125(b), which have elected to be exempted from the DRG PPS, subject to the limitations described in 89 Ill. Adm. Code 148.40(f) through 148.40(h).~~
- 8) ~~County Owned Hospitals and Hospitals Organized Under the University of Illinois Hospital Act. County owned hospitals located in an Illinois county with a population greater than three million and hospitals organized under the University of Illinois Hospital Act are excluded from the DRG system and are reimbursed under unique hospital specific reimbursement methodologies as described in 89 Ill. Adm. Code 148.160 and 148.170.~~
- d) ~~Excluded Distinct Part Hospital Units~~
- 1) ~~Distinct Part Psychiatric Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8) above, a hospital enrolled with the Department to provide inpatient psychiatric services (category of service 21) shall be excluded from the DRG PPS for the reimbursement of such inpatient psychiatric services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).~~
- 2) ~~Distinct Part Rehabilitation Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8) above, a hospital enrolled with the Department to provide inpatient rehabilitation services (category of service 22) shall be excluded from the DRG PPS for the reimbursement of such inpatient rehabilitation services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).~~

(Source: Amended at 38 Ill. Reg. 15477, effective July 2, 2014)

Section 149.75 Conditions for Payment Under the DRG Prospective Payment System

Effective for dates of discharge on or after July 1, 2014:

- a) **General Requirements**
- 1) A hospital must meet the conditions of this Section to receive payment under the DRG PPS for inpatient hospital services furnished to persons

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receiving coverage under the Medicaid Program.

- 2) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medical Assistance~~Medicaid~~ clients, the Department may, as appropriate:
 - A) Withhold Medicaid ~~payments~~ payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
 - B) Terminate the hospital's Provider Agreement pursuant to 89 Ill. Adm. Code 140.16.
- b) 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 Medical Assistance~~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, ~~2013~~1999). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 148.25(d)(1)~~Section 149.50(e)(1)~~, shall be in accordance with federal regulations.
- c) Medical Review Requirements: Admissions and Quality Review
Hospital utilization review committees, a subgroup of the utilization review committee, or the hospital's designated professional review organization (PRO) shall review, on an ongoing basis, the following:
 - 1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.
 - 2) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.
 - 3) The validity of the hospital's diagnostic and procedural information.
 - 4) The completeness, adequacy and quality of the services furnished in the

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hospital.

- 5) Other medical or other practice with respect to program participants or billing for services furnished to program participants.
- d) Medical Review Requirements: DRG Validation. The Department, or its agent, may require and perform pre- or-post-payment review of diagnosis and procedure codes to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records. The review may be undertaken by way of a sample of discharges. The review may, at the sole discretion of the Department, take place at the hospital or away from the hospital site.
- 1) ~~Coding attestation. Beginning with admissions on or after March 1, 1997, and ending with admissions on or after July 1, 2001, the Health Information Management Director (Medical Records) or his or her designee(s) within the Health Information Management Department must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal and secondary diagnoses, and major procedures as indicated in the medical record. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the signature of the Health Information Management Director or his or her designee(s) within this Department: "I certify that the ICD-9-CM coding of principal and secondary diagnoses and the major procedures performed are accurate and complete based on the contents of the medical record, to the best of my knowledge." The name of the person signing the attestation must be typed or clearly printed and appear on the same page as the signature.~~
 - 2) ~~DRG Validation. The Department, or its designated peer review organization, may require and perform prepayment review and/or postpayment review of specific diagnosis and procedure codes.~~
 - 3) ~~Sample Reviews~~
 - A) ~~The Department, or its designated peer review organization, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the~~

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~~Department for DRG assignment, is substantiated by the corresponding medical records.~~

~~B) Code validation must be done on the basis of a review of medical records and, at the Department's discretion, may take place at the hospital or away from the hospital site.~~

4) ~~Revision of Coding~~

~~A) If the diagnostic and procedural information, in compliance with the coding attestation requirements in subsection (d)(1) of this Section, is found to be inconsistent with the hospital's coding, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.~~

~~B) If the information, in compliance with the coding attestation requirements in subsection (d)(1) of this Section, is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.~~

e) Utilization Review Requirements: The Department, or its designated peer review organization, ~~(see as described in 89 Ill. Adm. Code 148.240(j))~~, may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews, as defined at 89 Ill. Adm. Code 148.240.

f) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1) The ~~applicable~~ payments made under the PPS are payment in full for all inpatient hospital services other than for the services of non hospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in ~~subsections~~ subsections (f)(1)(B)(i) through (v) of this Section.

A) Hospital-based physicians who may not bill separately on a fee-for-service basis are:

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- 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 are:
- 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 does, in fact, bill private patients and collect and retain the payments received.
 - v) A physician holding a nonteaching administrative or staff position in a hospital or medical school, ~~but only may bill separately on a fee for service basis~~ to the extent that he or she maintains a private practice and bills private patients

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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.

(Source: Amended at 38 Ill. Reg. 15477, effective July 2, 2014)

Section 149.100 ~~Basic~~ Methodology for Determining DRG ~~PPS~~ Prospective Payment Rates

Effective for dates of discharge on or after July 1, 2014:

- a) Inpatient hospital services that are not excluded from the DRG PPS pursuant to Section 149.50(b) shall be reimbursed as determined in this Section.
- b) Total DRG PPS Payment. Under the DRG PPS, services to inpatients who are:
 - 1) Discharges shall be paid pursuant to subsection (c).
 - 2) Transfers shall be paid pursuant to subsection (g).
 - 3) The total payment for an inpatient stay will equal the sum of the payment determined in subsection (c) or (g), as applicable, and any applicable adjustments to payment specified in 89 Ill. Adm. Code 148.290.
- c) DRG PPS Payment for Discharges. The reimbursement to hospitals for inpatient services based on discharges shall be the product, rounded to the nearest hundredth, of the following:
 - 1) The greater of:
 - A) 1.0000; or
 - B) highest policy adjustment factor, as defined in subsection (f), for which the inpatient stay qualifies.

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- 2) The sum of the DRG base payment, as defined in subsection (d), and any applicable outlier adjustment, as determined in Section 149.105, for which the claim qualifies.
- d) The DRG base payment for a claim shall be the product, rounded to the nearest hundredth, of:
- 1) The DRG weighting factor of the DRG and SOI, to which the inpatient stay was assigned by the DRG grouper.
 - 2) The DRG base rate, equal to the sum of:
 - A) The product, rounded to the nearest hundredth, of the Medicare IPPS labor share percentage, Medicare [inpatient prospective payment system \(IPPS\)](#) wage index, statewide standardized amount and [graduate medical education \(GME\)](#) factor.
 - B) The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage, the statewide standardized amount and the GME factor.
- e) Medicare IPPS [Wage Index](#). Medicare IPPS wage index is determined based on:
- 1) For Medicare IPPS hospitals that are in-state or are out-of-state Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system post-reclass wage index effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, [the wage index is based on the Medicare IPPS hospital post-reclass wage index effective October 1, 2012.](#)
 - 2) For in-state non-Medicare IPPS hospitals and out-of-state non-Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, [the wage index is based on](#)

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the Medicare IPPS wage index for the hospital's Medicare CBSA effective October 1, 2012.

- f) Policy Adjustments. Claims for inpatient stays that meet certain criteria may qualify for further adjustments to payment.
- 1) Transplantation Services
- A) Policy adjustment factor: 2.11.
- B) Qualifying Criteria
- i) The hospital meets all requirements to perform transplantation services, including but not limited to those detailed in 89 Ill. Adm. Code 148.82.
- ii) The claim has been grouped to one of the following DRGs:
- | | |
|------------|--------------------------------------|
| <u>001</u> | <u>Liver transplant.</u> |
| <u>002</u> | <u>Heart and/or lung transplant.</u> |
| <u>003</u> | <u>Bone marrow transplant.</u> |
| <u>006</u> | <u>Pancreas transplant.</u> |
| <u>440</u> | <u>Kidney transplant.</u> |
- 2) Trauma Services
- A) Policy adjustment factor:
- i) 2.9100, if the hospital is a level I trauma center.
- ii) 2.7600, if the hospital is a level II trauma center.
- B) Criteria:
- i) Hospital is recognized by the Department of Public Health as a level I or II trauma center on the date of admission.
- ii) The claim has been grouped to one of the following DRG:

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- 020 Craniotomy for trauma.
- 055 Head trauma, with coma lasting more than one hour or no coma.
- 056 Brain contusion/laceration and complicated skull fracture, coma less than one hour or no coma.
- 057 Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.
- 135 Major chest and respiratory trauma.
- 308 Hip and femur procedures for trauma, except joint replacement.
- 384 Contusion, open wound and other trauma to skin and subcutaneous tissue.
- 910 Craniotomy for multiple significant trauma.
- 911 Extensive abdominal/thoracic procedures for multiple significant trauma.
- 912 Musculoskeletal and other procedures for multiple significant trauma.
- 930 Multiple significant trauma, without operating room procedure.

3) Perinatal ServicesA) Policy adjustment factor:

- i) 1.3500, if the DRG to which the claim is grouped has an SOI of 1.
- ii) 1.4300, if the DRG to which the claim is grouped has an SOI of 2.
- iii) 1.4100, if the DRG to which the claim is grouped has an SOI of 3.
- iv) 1.5400, if the DRG to which the claim is grouped has an SOI of 4.

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- B) Criteria:
- i) Hospital was recognized by the Department of Public Health as a level III perinatal center on the date of admission.
 - ii) The claim has been grouped to one of the following major diagnostic categories (MDC):
 - 14 Pregnancy, childbirth and puerperium.
 - 15 Newborn and other neonates.
- 4) Safety Net
- A) Policy adjustment factor: \$57.50 per general acute care day.
 - B) Qualifying criteria: safety-net hospital defined in 305 ILCS 5/5-5e.1 excluding pediatric hospitals as defined in 89 Ill. Adm. Code 148.25(d)(3).
 - C) Effective: for dates of service on July 1, 2014 through June 30, 2018.
- g) DRG PPS Payment for Transfers. The reimbursement to hospitals for inpatient services provided to transfers shall be the lesser of:
- 1) The amount that would have been paid pursuant to subsection (c) had the inpatient been a discharge; or
 - 2) The product, rounded to the nearest hundredth, of the following:
 - A) The quotient resulting from dividing the amount that would have been paid pursuant to subsection (c) had the inpatient been a discharge by the DRG average length of stay for the DRG to which the inpatient claim has been assigned.
 - B) The length of stay plus the constant 1.0.

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h) Updates to DRG PPS Reimbursement. The Department may annually review the components listed in subsection (c) and make adjustments as needed. Grouper shall be updated at least triennially and no more frequently than annually.

i) Definitions

"Allocated static payments" means the adjustment payments made to the hospital pursuant to 89 Ill. Adm. Code 148.105, 148.115, 148.126, 148.295, 148.296 and 148.298 during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies outlined in rule as of February 21, 2014 (see <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>), as determined by the Department, allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Discharge" means a hospital inpatient that:

has been formally released from the hospital, except when the patient is a transfer; or

died in the hospital.

"DRG" means diagnosis related group, as defined in the DRG grouper, based on the principal diagnosis, surgical procedure used, age of patient, etc.

"DRG average length of stay" means, for each DRG and SOI combination, the national arithmetic mean length of stay for that combination rounded to the nearest tenth, as published by 3M Health Information Systems for the DRG grouper.

"DRG grouper" means the most recently released version of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during which the discharge occurred; except that, for the calendar year beginning January 1, 2014, DRG grouper means version 30 of the APR-DRG software.

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"DRG PPS" means the DRG prospective payment system described in this Part.

"DRG weighting factor" means each DRG and SOI combination shall equal the product, rounded to the nearest ten-thousandth, of the national weighting factor for that combination, as published by 3M Health Information Systems for the DRG grouper and the Illinois experience adjustment.

"GME factor" means the Graduate Medical Education factor applied to major teaching hospitals, as defined in 89 Ill. Adm. Code 148.25(h). Simulated payments under the new inpatient system with GME factor adjustments shall be \$3 million greater than simulated payments under the new inpatient system would have been without the GME factor adjustments, using inpatient base period paid claims data.

"Illinois experience adjustment" means:

for the calendar year beginning January 1, 2014, a quotient, computed by dividing the constant 1.0000 by the arithmetic mean 3M APR-DRG national weighting factors of claims for inpatient stays subject to reimbursement under the DRG PPS using inpatient base period paid claims data, rounded to the nearest ten-thousandth;

for subsequent calendar years, the factor applied to 3M APR-DRG national weighting factors, when updating DRG grouper versions determined such that the arithmetic mean DRG weighting factor under the new DRG grouper version is equal to the arithmetic mean DRG weighting factor under the prior DRG grouper version using inpatient base period claims data.

"Inpatient base period claims data" means: State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for DRG PPS payment for services provided in State fiscal years 2015, 2016 and 2017; for subsequent dates of service, the most recently available adjudicated 12 months of inpatient paid claims data to be identified by the Department.

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"Inpatient stay" means a formal admission into a hospital, pursuant to the order of a licensed practitioner permitted by the state in which the hospital is located to admit patients to a hospital that requires at least one overnight stay.

"Length of stay" means the number of days the patient was an inpatient in the hospital, with the day the patient became a discharge or transfer not counting toward the length of stay.

"Medical assistance" means one of the programs administered by the Department that provides health care coverage to Illinois residents.

"Medicare CBSA" means the Core-Based Statistical Areas for a hospital's location effective in the Medicare inpatient prospective payment system at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

"Medicare IPPS labor share percentage" means the Medicare inpatient prospective payment system operating standardized amount labor share percentage for the federal fiscal year ending three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the labor share percentage in the Medicare inpatient prospective payment system for the federal fiscal year beginning October 1, 2012, which is 0.6880 for a hospital with a Medicare IPPS wage index greater than 1.0 or 0.6200 for all other hospitals.

"Medicare IPPS non-labor share" means the difference of 1.0 and the Medicare IPPS labor share percentage.

"MDC" means major diagnostic category – group of similar DRGs, such as all those affecting a given organ system of the body.

"SOI" means one of four subclasses of each DRG, as published by 3M Health Information Systems for the DRG grouper that relate to severity of illness (the extent of physiologic decompensation or organ system loss of function experienced by the patient) and risk of (the likelihood of) dying.

"Statewide standardized amount" means the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS

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payments, without SMART Act reductions or GME factor adjustments, using general acute hospital inpatient based period paid claims data, are \$355 million less than the sum of inpatient based period paid claims data reported payments and allocated inpatient static payments.

"Transfer" means a hospital inpatient that has been placed in the care of another hospital, except that a transfer does not include an inpatient claim that has been assigned to DRG 580 (Neonate, transferred, less than five days old, not born here) or 581 (Neonate, transferred, less than five days old, born here).

a) ~~DRG Classification and Weighting Factors~~

1) ~~DRG Classification. The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), to classify inpatient hospital discharges by diagnosis related groups (DRGs) as defined by federal regulation for the Medicare Program (42 CFR 412), with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.~~

2) ~~DRG Weighting Factors~~

A) ~~Except as provided in subsections (a)(2)(B) through (a)(2)(E) below, the Illinois Medicaid weighting factor for each DRG shall equal the Medicare weighting factor, as described in Section 149.5(c)(2), for that group, multiplied by a fraction, the numerator of which is the Medicaid geometric mean length of stay and the denominator of which is the Medicare geometric mean length of stay for that group. In making that calculation, the Department shall:~~

i) ~~Use the Medicare geometric mean length of stay for each diagnostic related group as determined by the Health Care Financing Administration of the United States Department of Health and Human Services.~~

ii) ~~Calculate the Medicaid geometric mean length of stay for each diagnostic related group using the same methodology employed to calculate the Medicare geometric mean length~~

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~~of stay and using data obtained from the Illinois Health Care Cost Containment Council or the Department's data bases.~~

- ~~B) The Illinois weighting factors for neonatal discharges (Medicare-defined DRGs 385-391 and Illinois-defined DRGs for Level III perinatal centers) shall be the product of the ratio of the mean cost per discharge (defined below) of the given DRG to the mean cost per discharge for DRG 391 (normal newborn) and the Medicare scaling factor (defined below), such that the Illinois and Medicare weighting factors for DRG 391 are the same.~~
- ~~i) Mean cost per discharge, for any DRG, is defined as the sum of the product of charges, as reported by a hospital on claims paid by the Department, less costs for capital, direct and indirect medical education, updated to the current rate year using the national hospital market basket price proxies (DRI) and the hospital's cost to charge ratio, as derived from the hospital's most recent audited cost report divided by the number of discharges for that DRG.~~
- ~~ii) Medicare scaling factor is defined as the Medicare weighting factor for DRG 391 (normal newborns).~~
- ~~C) The Illinois weighting factors for psychiatric discharges (DRGs 424-432) shall be computed as specified in subsections (a)(1) and (a)(2) except, prior to computing the Medicaid geometric mean length of stay for those DRGs, all lengths of stay longer than three (3) days are to be set at three (3) days.~~
- ~~D) The Illinois weighting factors for DRGs that will not be paid through the DRG PPS are zero (0.0000). Those include DRG 103, heart transplant; DRG 436, alcohol/drug dependence with rehabilitation therapy; DRG 462, rehabilitation; DRG 480, liver transplant; DRG 481, bone marrow transplant; DRG 495, lung transplant.~~
- ~~E) Except for DRGs otherwise specified in subsections (a)(2)(B)~~

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~~through (a)(2)(D), the Illinois weighting factors for DRGs for which available historic discharge data are sparse, fewer than 100 records, shall be computed using an alternate methodology.~~

- ~~i) For rate periods beginning on or after October 1, 1992, for those DRGs with 32 or more records available, the Illinois weighting factor shall be set at the midpoint between the weight calculated using the methodology in subsection (a)(2)(A) and the Medicare weighting factor, as described in Section 149.5(c)(2).~~
 - ~~ii) For those DRGs with fewer than 32 records available, the Illinois weighting factor shall be set equivalent to the Medicare weighting factor, as described in Section 149.5(c)(2).~~
- 3) ~~Assignment of Discharges to DRGs. The Department will establish a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG, based on essential data abstracted from the inpatient bill for that discharge.~~
- ~~A) The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.~~
 - ~~B) Each discharge will be assigned to only one DRG (related, except as provided in subsection (a)(3)(C), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.~~
 - ~~C) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be subject to prepayment review for validation and reverification. The Department's DRG classification system will provide a DRG, and an appropriate weighting factor, for cases for which the~~

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~~unrelated diagnosis and procedure are confirmed.~~

4) ~~Review of DRG Assignment~~

- A) ~~A hospital has 60 days after the date of the remittance advice indicating initial assignment of a discharge to a DRG to request a review of the assignment. The hospital may submit additional information as a part of its request.~~
- B) ~~The Department shall review the hospital's request and any additional information and decide whether a change in the DRG assignment is appropriate. If the Department decides that a higher-weighted DRG should be assigned, it must request the Department's peer review organization to review the case to verify the change in DRG assignment.~~
- C) ~~Following the 60-day period described in subsection (a)(4)(A) above, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.~~

b) ~~Illinois Rates for Admission~~

- 1) ~~Reimbursement to hospitals for claims for admissions occurring prior to October 1, 1992, shall be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The payments described in Sections 149.5 through 149.150 and 89 Ill. Adm. Code 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992, subject to 89 Ill. Adm. Code 148.20(b) and Section 149.5(b).~~
- 2) ~~The payments described in 89 Ill. Adm. Code 148.82 shall be effective for services provided on or after July 1, 1992.~~

e) ~~Determining Prospective Payment Rates~~1) ~~Federal/Regional Blended Rate Per Discharge~~

- A) ~~Except as specified in subsection (c)(1)(B) below, the Department~~

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~~shall reimburse hospitals for inpatient services at the federal/regional blended rate per discharge for the Medicare Program, which includes the hospital-specific portion as described in subsection (c)(2) below, if applicable, and as computed by the PPS Pricer, as described in Section 149.5(c)(3).~~

B) ~~In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), on July 15, 1993:~~

i) ~~Effective with admissions occurring on October 1, 1993, and for the duration of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Department shall recompute such hospital's DRG-PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect on September 1, 1992, under the Medicare Program.~~

ii) ~~Effective with admissions occurring on or after the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall compute such hospital's DRG-PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect 90 days prior to the date of admission, under the Medicare Program.~~

2) ~~Hospital-Specific Portion
The hospital-specific portion is defined as the specific status and any applicable add-ons under the Medicare Program in recognition of sole community hospitals, rural referral centers and Medicare dependent hospitals, and rural hospitals deemed urban.~~

3) ~~DRG-PPS Base Rate
The DRG-PPS base rate shall be defined as the sum of the amounts computed under subsections (c)(1) and (c)(2), multiplied by the Illinois weighting factor assigned to the DRG into which the case has been classified.~~

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- 4) Payment Adjustments
~~In addition to the DRG PPS base rate defined in subsection (c)(3), hospitals shall receive applicable outlier adjustments, in accordance with Section 149.105; applicable adjustments for capital costs in accordance with Section 149.150(c); applicable adjustments for disproportionate share, in accordance with 89 Ill. Adm. Code 148.120; applicable adjustments for uncompensated care, in accordance with 89 Ill. Adm. Code 148.150; various specific inpatient payment adjustments, as applicable, in accordance with 89 Ill. Adm. Code 148.290.~~
- d) Application of Upper Payment Limits. ~~The Department shall adjust each of the prospective payment rates determined under subsection (c) above (with the exception of disproportionate share payment adjustments made in accordance with 89 Ill. Adm. Code 148.120) to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.~~

(Source: Amended at 38 Ill. Reg. 15477, effective July 2, 2014)

Section 149.105 Payment For Outlier Cases

Effective for dates of discharge on or after July 1, 2014:

- a) Outlier adjustment determination. ~~Except as provided in subsection (b), the Department may provide for additional payment, approximating a hospital's marginal cost of covered inpatient hospital services beyond thresholds specified by the Department. To qualify for the payment, the claim must meet the following criteria:~~General Provisions
- 1) The services on the claim must be reimbursable under the DRG PPS. ~~Except as provided in subsections (a)(3) and (a)(4) of this Section, the Department provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by the Department, to a hospital for covered inpatient hospital services furnished to a Medicaid client, if either of the conditions in the following subsections (A) or (B) apply. The client's length of stay (including up to three administrative~~

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~~days) exceeds the day outlier threshold, determined by the Department, for the appropriate applicable DRG.~~

A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the threshold is set at the lesser of the geometric mean length of stay plus 27 days, or the geometric mean length of stay plus three standard deviations.~~

B) ~~For rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the geometric mean length of stay plus the lesser of three standard deviations, or the Medicare day outlier cutoff threshold in effect 90 days prior to the date of admission, adjusted by a factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the average Medicare geometric mean length of stay.~~

2) ~~The DRG grouper must be able to assign the claim to a DRG. The hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost to charge ratio, as described in subsection (c)(3) of this Section, exceed the greater of:~~

A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), \$34,000 as adjusted for the hospital's labor market, or the hospital's DRG-PPS base rate as described in Section 149.100(c)(1) multiplied by two.~~

B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the Medicare established cost outlier cutoff threshold in effect 90 days prior to the date of admission.~~

3) ~~The estimated claim cost for a claim exceeds the claim outlier threshold for the DRG to which the claim has been assigned. The Department will provide cost outlier payments to a transferring hospital reimbursed under the DRG-PPS that does not receive payment under subsection (b) of this Section for discharges specified in Section 149.25(b)(4)(B), if the hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost to charge ratio, as described in subsection (c)(3),~~

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~~exceed:~~

- ~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the greater of the criteria specified in subsection (a)(2)(A) of this Section.~~
 - ~~B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the criteria specified in subsection (a)(2)(B) of this Section.~~
- ~~4) The Department will not provide outlier payments for:~~
- ~~A) Discharges classified as psychiatric care (DRGs 424-432). Such care provided by other than hospitals or distinct part units enrolled with the Department to provide psychiatric care (category of service 21) is limited to emergency treatment, to last no longer than three days.~~
 - ~~B) Discharges assigned to DRGs with an Illinois weighting factor of zero (0.0000).~~
- ~~5) The Department or its designee may review outlier cases on a prepayment or postpayment review basis. The charges for any services identified as noncovered through this review will be denied and any outlier payment having been made for those services will be recovered, as appropriate, after a determination as to the provider's liability has been made. If the Department or its designee finds a pattern of inappropriate utilization by a hospital, all outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the Department or its designee determines that appropriate corrective actions have been taken. The Department, or its designee, must review and approve, to the extent required by the Department:~~
- ~~A) The admission was medically necessary and appropriate.~~
 - ~~B) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay.~~

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- ~~C) The services were ordered by the physician, actually furnished, and nonduplicatively billed.~~
 - ~~D) The validity of the diagnostic and procedural coding.~~
 - ~~E) The granting of up to three administrative (grace) days during which the hospital is seeking an appropriate setting into which to discharge a nonacute patient.~~
- b) Estimated Claim Cost. Estimated claim cost is based on the product of the claim total covered charges and the hospital's Medicare IPPS outlier cost-to-charge ratio. The Medicare IPPS outlier cost-to-charge ratio is determined based on: Payment for Extended Length-of Stay Cases (Day Outliers)
- 1) For Medicare IPPS hospitals, the outlier cost-to-charge ratio is based on the sum of the Medicare inpatient prospective payment system hospital-specific operating and capital outlier cost-to-charge ratios effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred. If the hospital stay includes covered days of care beyond the applicable threshold criterion, the Department will make an additional payment, on a per diem basis, to the discharging hospital for those days and the transferring hospital for DRG 385, 456, or 985 only. A special request or submission is not necessary to initiate this payment.
 - 2) For non-Medicare IPPS hospitals, the outlier cost-to-charge ratio is based on the sum of the Medicare inpatient prospective payment system statewide average operating and capital outlier cost-to-charge ratios for urban hospitals for the state in which the hospital is located, effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred. Except as provided in subsection (d) of this Section, and subject to the limitations described in subsection (e) of this Section, the per diem payment made under subsection (b)(1) is derived by first taking the marginal cost factor, as defined in 89 Ill. Adm. Code 149.5(e)(4), of the per diem payment for the applicable DRG, as calculated by dividing the DRG PPS base rate, determined under Section 149.100(e)(3), by the mean length-of-stay for that DRG.

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- 3) ~~Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.~~
- c) Exclusions. No outlier adjustment shall be paid on claims that are excluded from the DRG PPS pursuant to Section 149.50(b). Payments for Extraordinarily High Costs Cases (Cost Outliers)
- 1) ~~If the hospital charges, as adjusted by the method specified in subsection (c)(3), exceed the applicable threshold criterion, the Department will make an additional payment to the hospital to cover those costs. A special request or submission is not necessary to initiate this payment.~~
- 2) ~~The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost to charge ratio as described in subsection (c)(3), subject to the limitations described in subsections (c)(4) and (e) of this Section.~~
- 3) ~~The cost to charge ratio used to adjust covered charges is computed at the beginning of each rate period, as described in 89 Ill. Adm. Code 148.25(g)(2), by the Department for each hospital based on the hospital's base fiscal year. Statewide cost to charge ratios are used in those instances in which a hospital's cost to charge ratio falls outside reasonable parameters or cannot be computed due to a lack of information (e.g., a new hospital for which the Department is not in possession of the required historical information).~~
- 4) ~~If any of the services are determined to be noncovered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.~~
- 5) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall employ the same methodologies and rates used by Medicare, to calculate additional payments for cost outliers.~~
- d) Outlier Adjustment Payment. The amount of the additional payment shall be

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determined as the product, rounded to the nearest hundredth, of:

- 1) the difference resulting from subtracting the claim outlier threshold from the estimated claim cost; and
- 2) the applicable SOI adjustment factor, rounded to the nearest hundredth.

~~Payment for Extraordinary High Cost Day Outliers. If a discharge qualifies for an additional payment under the provisions of both subsections (b) and (c), the additional payment is, subject to the limitations described in subsection (e) of this Section, the greater of the following:~~

- ~~1) The payment computed under subsection (b) above.~~
- ~~2) The payment computed under subsection (c) above.~~

e) Definitions

In addition to terms elsewhere defined in this subchapter, terms relating to outlier adjustments are defined as follows:

"Claim outlier threshold" means the sum of the DRG base payment, as defined in Section 149.100(d) and the fixed loss threshold.

"Fixed loss threshold" means the Medicare fixed loss threshold in effect on October 1, 2012. The Department is authorized to update the "fixed loss threshold". Base rates must be updated within 12 months **after** the update.

"MDC" means major diagnostic category.

"Medicare CBSA" means the Core-Based Statistical Areas for a hospital's location effective in the Medicare inpatient prospective payment system at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

SOI adjustment factor" means for SOI 1, 0.8000; for SOI 2, 0.8000; for SOI 3, 0.9500; for SOI 4, 0.9500.

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"Total covered charges" means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMMS 1450), or one of its electronic transaction equivalents.

~~Outlier Payment Limitation. Notwithstanding any other provisions of this Section, the total reimbursement paid by the Department, excluding payments described in 89 Ill. Adm. Code 148.120, for a claim qualifying for an outlier payment under this Section shall not exceed the total covered inpatient charges.~~

(Source: Amended at 38 Ill. Reg. 15477, effective July 2, 2014)

Section 149.125 Special Treatment of Certain Facilities (Repealed)

a) General Rules

- 1) ~~Sole Community Hospitals. Hospitals defined as sole community hospitals shall, under subsection (b) below, shall have the choice of being reimbursed under the DRG PPS methodology, as described in Sections 149.5 through 149.150, or the Department's Alternate Reimbursement methodology as described in 89 Ill. Adm. Code 148.250 through 148.300, in accordance with the provisions of 89 Ill. Adm. Code 148.40(f) through (h).~~
- 2) ~~Hospitals that Serve a Disproportionate Share of Low Income Patients. The Department shall make additional payments to hospitals that serve a disproportionate share of low income patients. The criteria and methodologies for such additional payments are set forth in 89 Ill. Adm. Code 148.120.~~
- 3) ~~Specific Inpatient Payment Adjustments. The Department shall make specific additional payments to applicable hospitals as set forth in 89 Ill. Adm. Code 148.290.~~

b) ~~Criteria for Classification as a Sole Community Hospital. "Medicaid Sole Community Provider" means a hospital that meets one of the following criteria:~~

- 1) ~~Medicare Program Designation~~

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- A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective September 1, 1992.~~
- B) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(B), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare program effective 90 days prior to the date of admission.~~
- 2) ~~Primary Service Area Designation~~
- A) ~~Any rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), that serves 55 percent or more of the Medicaid patients residing within the hospital's primary service area for the provision of inpatient hospital services.~~
- B) ~~"Primary service area" means the geographic area defined by U.S. Postal Service Zip Codes in which 50 percent or more of a hospital's inpatients reside.~~
- 3) ~~The determination of sole community provider status under this subsection (b) shall be made prior to the rate period, as described in 89 Ill. Adm. Code 148.25(g)(2).~~
- 4) ~~The data used to make this determination will be from the Illinois Health Care Cost Containment Council (IHCCCC) for the most recent four quarters for which information is available.~~

(Source: Repealed at 38 Ill. Reg. 15477, effective July 2, 2014)

Section 149.150 Payments to Hospitals Under the DRG Prospective Payment System
(Repealed)

- a) ~~Total Medicaid Payment. Under the DRG PPS, the total payment for inpatient~~

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~~hospital services furnished to a Medicaid client by a hospital will equal the sum of the payments listed in subsections (b) through (c). In addition to the payments listed in subsections (b) through (c) of this Section, hospitals shall also receive disproportionate share adjustments in accordance with 89 Ill. Adm. Code 148.120, if applicable, uncompensated care adjustments in accordance with 89 Ill. Adm. Code 148.150, if applicable, and various specific inpatient payment adjustments in accordance with 89 Ill. Adm. Code 148.290, if applicable.~~

- b) ~~Payments Determined on a Per Case Basis. A hospital will be paid on a per case basis (with the exception of kidney acquisition costs) the following amounts:~~
- ~~1) the appropriate DRG PPS rate for each discharge as determined in accordance with Section 149.100(c).~~
 - ~~2) The appropriate outlier payment amounts determined under Section 149.105.~~
 - ~~3) Capital related costs as determined under subsection (c)(1)(A) of this Section.~~
- e) ~~Payments for Capital Costs. For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) these costs shall be paid on a per case basis. For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), these costs shall be paid on a per diem basis. Payments for these costs shall be calculated as follows:~~
- ~~1) Capital Related Costs~~
 - ~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A):~~
 - ~~i) The capital related cost per diem shall be calculated by taking the hospital's total capital related costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies (DRI).~~

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- ii) ~~These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.~~
 - iii) ~~The adjusted capital related cost per diem amount, as calculated in subsection (c)(1)(A)(ii) above, shall be rank ordered for all hospitals and capped at the 80th percentile.~~
 - iv) ~~Each hospital shall receive a per case add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG-PPS.~~
- B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B):~~
- i) ~~Capital related cost per diem shall be calculated in accordance with subsections (c)(1)(A)(i) through (c)(1)(A)(iii) of this Section.~~
 - ii) ~~Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) of this Section, whichever is less.~~
- 2) ~~A hospital wishing to appeal the calculation of its rates must notify the Department within 30 days after receipt of the rate change notification.~~
- d) ~~Method of Payment~~
- 1) ~~General Rule. Unless the provisions of subsection (d)(2) of this Section apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded distinct part psychiatric or a rehabilitation unit of a hospital are made in accordance with 89 Ill. Adm. Code 148.270(b).~~

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- 2) ~~Special Interim Payment for Unusually Long Lengths of Stay~~
- A) ~~First Interim Payment. A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.~~
- B) ~~Additional Interim Payments. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under subsection (d)(2)(A) of this Section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of subsection (d)(2).~~
- 3) ~~Outlier Payments. Except as provided in subsection (d)(2) of this Section, payment for outlier cases (described in Section 149.105) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.~~
- e) ~~Reductions to Total Payments~~
- 1) ~~Copayments. Copayments are assessed in accordance with 89 Ill. Adm. Code 148.190.~~
- 2) ~~Third Party Payments. Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.~~
- f) ~~Effect of Change of Ownership on Payments Under the DRG Prospective Payment System. When a hospital's ownership changes, the following rule~~

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~~applies: Payment for the cost of inpatient hospital services for each patient, including outlier payments, as provided under subsection (b) of this Section, will be made to the entity that is the legal owner on the date of discharge. Payments will not be prorated between the buyer and seller.~~

- ~~1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.~~
- ~~2) Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of the information is attributable to a period during which a different party legally owned the hospital.~~

(Source: Repealed at 38 Ill. Reg. 15477, effective July 2, 2014)

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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	Amendment
152.150	Amendment
152.200	Repeal
152.300	Amendment
152.350	New Section
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11]
- 5) Effective Date of Rule: July 2, 2014
- 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 rule, 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 21, 2014; 38 Ill. Reg. 4977
- 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 152.150 of Part 152, added a new subsection to read as follows: "(c) Public Act 98-651, effective June 16, 2014, authorizes the Department, after consulting with the hospital community, to replace this Section within 12 months after its effective date. If the Department does not file rules to replace this Section within 12 months after the effective date of PA 98-651, this Section as amended effective July 1, 2014 shall remain in effect until modified by rule by the Department. *Nothing in PA 98-651 shall be*

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construed to mandate that the Department file a replacement rule [305 ILCS 5/14-12(c)].".

In Part 152 added a new Section "152.350 Inpatient and Outpatient Rate Adjustments" to read as follows: "Notwithstanding anything to the contrary in 89 Ill. Adm. Code 140, 146, 148, 149 and 152, any updates to the system shall not result in any diminishment of the overall effective rate of reimbursement as of the implementation date of the new system (July 1, 2014). These updates shall not preclude variations in any individual component of the system or hospital rate variations. Nothing in 89 Ill. Adm. Code 140, 146, 148, 149 and 152 shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors including, but not limited to, number of individuals in the medical assistance program and severity of illness of the individuals."

- 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 rule currently in effect? No
- 14) Are there any other rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform. These rules have also been modified based on negotiations for SB 741 of the 98th General Assembly which became law June 16, 2014 (PA 98-651).
- 16) Information and questions regarding this adopted rule shall be directed to:
Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd 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 Hospital Rate Reductions

152.150 [Hospital Payment Documentation and Coding Improvement Adjustment](#)~~Diagnosis
Related Grouping (DRG) Prospective Payment System (PPS)~~152.200 Non-DRG Reimbursement Methodologies ([Repealed](#))152.250 Appeals ([Repealed](#))

152.300 Adjustment for Potentially Preventable Readmissions

[152.350 Inpatient and Outpatient Rate Adjustments](#)

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

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Ill. Reg. 282, effective January 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 10517, effective June 27, 2013; emergency amendment at 37 Ill. Reg. 13589, effective August 1, 2013, for a maximum of 150 days; emergency amendment at 37 Ill. Reg. 16003, effective September 27, 2013, for a maximum of 150 days; amended at 38 Ill. Reg. 882, effective December 23, 2013; amended at 38 Ill. Reg. 15527, effective July 2, 2014.

Section 152.100 Hospital Rate Reductions

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, and with implementation of SMART hospital payment reform rates in effect on July 1, 2014, 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 as defined in 89 Ill. Adm. Code 148.25(g), 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 Illinois Public Aid Code.
- e) Transitional payment authorized in 89 Ill. Adm. Code 148.296.

(Source: Amended at 38 Ill. Reg. 15527, effective July 2, 2014)

Section 152.150 Hospital Payment Documentation and Coding Improvement Adjustment~~Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)~~

Effective for dates of service on or after July 1, 2014:

- a) Inpatient Hospital Payment Documentation and Coding Improvement (DCI)

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~~Adjustment Notwithstanding any provisions set forth in 89 Ill. Adm. Code 149, the changes described in subsections (b) and (c) of this Section will be effective January 18, 1994.~~

- 1) The Department shall monitor changes in inpatient hospital statewide average case mix for services provided in the first two years following implementation of the APR-DRG payment methodology, and retrospectively adjust DRG base rates to offset the impact of paid case mix differential attributable to DCI.
- 2) Measuring case mix differential attributable to DCI:
 - A) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 30 of the Medicare-Severity DRG (MS-DRG) grouper and relative weights for:
 - i) Claims with dates of service in State fiscal year 2011.
 - ii) Claims with dates of service in State fiscal years 2015 and 2016, consistent with subsection (a)(3).
 - B) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 30 of the APR-DRG weighting factors for the same periods specified in subsection (a)(1)(A).
 - C) The case mix differential that is attributable to DCI is equal to the difference between the change in the aggregate APR-DRG case mix and the change in the aggregate MS-DRG case mix for the claims described in subsection (a)(1)(A).
 - D) Claims for services provided in State fiscal years 2015 and 2016 that were not paid by the Department using the APR-DRG payment methodology shall be excluded when measuring the case mix differential.
- 3) Timing:

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- A) Calculate case mix differential attributable to DCI for claims with Dates of Service (DOS) in SFY 2015 (first year of implementation) as of:
- i) July 1, 2015, using all claims adjudicated as of that date with DOS in SFY 2015.
 - ii) January 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.
 - iii) April 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.
- B) Calculate case mix differential attributable to DCI for claims with DOS in SFY 2016 (second year of implementation) as of:
- i) July 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2016.
 - ii) January 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.
 - iii) April 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.
- 4) Adjusting for case mix changes attributable to DCI:
- A) For any measurement period described in subsection (a)(3), if the case mix differential attributable to DCI is greater than two percentage points, the Department will adjust the DRG base rates by the measured case mix differential less two percentage points.
 - B) For any measurement period described in subsection (a)(3), if the case mix differential attributable to DCI is less than minus two percentage points, the Department will adjust the DRG base rates by the measured case mix differential plus two percentage points.

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- C) The Department will retroactively adjust the payments for all claims adjudicated as of the measurement period for the changes in the DRG base rates.
- b) Outpatient Hospital Payment Documentation and Coding Improvement Adjustment For the rate periods, as described in 89 Ill. Adm. Code 148.25(g)(2)(B), the DRG weighting factors shall be adjusted by a factor, the numerator of which is the statewide weighted average DRG base payment rate in effect for the base period, as described in 89 Ill. Adm. Code 148.25(g)(2)(A), and the denominator of which is the statewide weighted average DRG base payment rate for the rate period, as described in 89 Ill. Adm. Code 148.25(g)(2)(B). For this adjustment, DRG base payment rate means the product of the PPS base rate, as described in 89 Ill. Adm. Code 149.100(e)(3), and the indirect medical education factor, as described in 89 Ill. Adm. Code 149.150(e)(3).
- 1) The Department shall monitor changes in outpatient hospital case mix for services provided in the first two years following implementation of the Enhanced Ambulatory Procedure Grouping (EAPG) payment methodology, and retrospectively adjust EAPG conversion factors to offset the impact of the case mix differential attributable to DCI.
- 2) Measuring case mix differential attributable to DCI:
- A) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Ambulatory Procedures List (APL) relative values for the claims data periods listed in this subsection (b)(2)(A). Relative values will be determined for each APL using SFY 2011 outpatient claims data by dividing the APL's average payment per service unit by the statewide APL payment for service unit.
- i) Claims with DOS in SFY 2011.
- ii) Claims with DOS in SFY 2015 and 2016, consistent with subsection (b)(3).
- B) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 3.7 of the

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EAPG grouper and the EAPG weighting factors for the same periods.

- C) The case mix differential that is attributable to DCI is equal to the difference between the change in the aggregate EAPG case mix and the change in the aggregate APL case mix, for the claims described in subsections (b)(2)(A)(i) and (ii).
- D) Claims for services provided in SFY 2015 and 2016 that were not paid by the Department using the EAPG payment methodology shall be excluded when measuring the case mix differential.

3) Timing:

- A) Calculate case mix differential attributable to DCI for claims with DOS in SFY 2015 (first year of implementation) as of:
 - i) July 1, 2015, using all claims adjudicated as of that date with DOS in SFY 2015.
 - ii) January 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.
 - iii) April 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.
- B) Calculate case mix differential attributable to DCI for claims with DOS in SFY 2016 (second year of implementation) as of:
 - i) July 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2016.
 - ii) January 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.
 - iii) April 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.

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- 4) Adjusting for case mix changes attributable to DCI:
- A) For any measurement period described in subsection (b)(3), if the case mix differential attributable to DCI is greater than two percentage points, the Department will adjust the EAPG conversion factor by the measured case mix differential less two percentage points.
 - B) For any measurement period described in subsection (b)(3), if the case mix differential attributable to DCI is less than minus two percentage points, the Department will adjust the EAPG conversion factor by the measured case mix differential plus two percentage points.
 - C) The Department will retroactively adjust the payments for all claims adjudicated as of the measurement period for the changes in the EAPG conversion factors.
 - D) The EAPG conversion factor, after adjustments pursuant to subsections (b)(4)(A) and (B), shall be in effect until the next measurement period.
- c) Public Act 98-651, effective June 16, 2014, authorizes the Department, after consulting with the hospital community, to replace this Section within 12 months after its effective date. If the Department does not file rules to replace this Section within 12 months after the effective date of PA 98-651, this Section as amended effective July 1, 2014 shall remain in effect until modified by rule by the Department. Nothing in PA 98-651 shall be construed to mandate that the Department file a replacement rule [305 ILCS 5/14-12(c)].
- e) ~~All payments calculated under 89 Ill. Adm. Code 149.140 and 149.150(c)(1), (c)(2) and (c)(4), in effect on January 18, 1994, shall remain in effect hereafter.~~
- d) ~~For hospital inpatient services rendered on or after July 1, 1995, the Department shall reimburse hospitals using the relative weighting factors and the base payment rates calculated pursuant to the methodology described in this Section, that were in effect on June 30, 1995, less the portion of such rates attributed by the Department to the cost of medical education.~~

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- e) ~~Notwithstanding the provisions set forth in 89 Ill. Adm. Code 149 (DRG PPS), the changes described in this subsection (e) shall be effective January 1, 2001. Payments for hospital inpatient and outpatient services shall not exceed charges to the Department. This 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 149.105 or payments for Medicaid High Volume Adjustments as described at 89 Ill. Adm. Code 148.290(d).~~
- f) ~~Notwithstanding the provisions of 89 Ill. Adm. Code 149, payment for outlier cases pursuant to 89 Ill. Adm. Code 149.105 shall be determined by using the following factors that were in effect on June 30, 1995:~~
- ~~1) The marginal cost factor (see 89 Ill. Adm. Code 149.5(c)(4));~~
 - ~~2) The Metropolitan Statistical Area (MSA) wage index (see 89 Ill. Adm. Code 148.120(b));~~
 - ~~3) The Indirect Medical Education (IME) factor (see 89 Ill. Adm. Code 148.260(a)(1)(B)(iv));~~
 - ~~4) The cost to charge ratio (see 89 Ill. Adm. Code 149.105(c)(3)), and~~
 - ~~5) Outlier Threshold~~
 - ~~A) For admissions on December 3, 2001 through June 30, 2005, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.22.~~
 - ~~B) For admissions on or after July 1, 2005 through June 30, 2006, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.40.~~
 - ~~C) For admissions on or after July 1, 2006 through December 31, 2007, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.47.~~

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- D) ~~For admissions on or after January 1, 2008, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.64.~~
- E) ~~For admissions on or after January 1, 2011, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.99.~~

(Source: Amended at 38 Ill. Reg. 15527, effective July 2, 2014)

Section 152.200 Non-DRG Reimbursement Methodologies (Repealed)

- 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), (e) 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.~~
- e) ~~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 payment limitation shall not apply to government owned or operated hospitals or children's hospitals as defined at 89 Ill. Adm. Code 149.50(e)(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~~

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~~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 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: Repealed at 38 Ill. Reg. 15527, effective July 2, 2014)

Section 152.300 Adjustment for Potentially Preventable Readmissions

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- a) Notwithstanding any provision set forth in 89 Ill. Adm. Code 148 or 149 and unless otherwise stated in this Section, 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). For State fiscal year 2013, the Potentially Preventable Readmission (PPR) methodology, version 27 of the definitions manual applicable to the 3M Potentially Preventable Readmissions Grouping Software created and maintained by the 3M Corporation will be used by HFS to process admissions data and determine whether an admission is a Potentially Preventable Readmission. This version is available by registering at the following link: https://support.3mhis.com/app/answers/detail/a_id/4133/kw/PPR. For the State fiscal year 2014 PPR methodology, version 29 of the definitions manual applicable to the PPR software created and maintained by the 3M Corporation will be used by HFS to process admissions data and determine whether an admission is a Potentially Preventable Admission. This version is available by registering at the link referenced above. Beyond State fiscal year 2014, the version that the Department will utilize will be updated in rule as soon as the information becomes available to the Department. Except when other definitions and criteria applicable to PPR are specified in this Section, the methodology applied by the 3M PPR Grouping Software and contained in the Potentially Preventable Readmissions Classification System Methodology Overview (GRP-139, May 2008, no later amendments or editions included) published by 3M Health Information Systems, 575 West Murray Blvd., Salt Lake City UT 84123, and accessible at <http://www2.illinois.gov/hfs/SiteCollectionDocuments/3MPotentiallyPreventableReadmissions.pdf>, is incorporated by reference.
 - 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.

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- 2) "Hospital" shall mean a hospital as defined in 89 Ill. Adm. Code 148.25(b).
- 3) "Base Year" shall mean State fiscal year 2010 and it is the initial data year the Department used to calculate the statewide average PPR rate. Each hospital Current Year is compared to the Base Year to measure the hospital's PPR performance over time.
- 4) "Current Year" shall mean the State fiscal year in which Targeted Rate of Readmission is set for hospitals to achieve their Targeted Rates of Readmission.
- 5) "Data Year" shall mean the most recent fully adjudicated claims data in a State fiscal year available to the Department, which is used to calculate the Actual Rate of Readmission and the Targeted Rate of Readmission for each hospital.
- 6) "Clean Claim" shall mean a claim as defined in 42 CFR 447.45(b).
- 7) "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 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.
- 8) "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.
- 9) "Only Admission" shall mean an admission without an associated readmission.
- 10) "Potentially Preventable Readmission Chain" or "PPR Chain" shall mean an initial admission occurring at a hospital that is followed by one or more

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clinically-related PPRs. The PPRs may occur at the same hospital or a different hospital.

- 11) "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).
- 12) "Actual Rate" shall mean the number of PPR Chains for a hospital divided by the total number of qualifying admissions for the hospital.
- 13) "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.
- 14) "Excess Rate of Readmission" shall mean the difference between the actual rate of readmission and the targeted rate of readmission for each hospital.
- 15) "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.
- 16) As of August 1, 2013, "Pediatric/Behavioral Health Factor" shall mean a factor that is a calculation of PPR for both children and adults with and without a secondary diagnosis of Behavioral Health. This is a risk adjustment factor. This factor is multiplied by a hospital's Actual Rate of PPR at the service level before it is compared to the statewide average rate of PPR in order to calculate the hospital's Actual Rate of readmission. There are three categories of factors that are calculated and within each category there are three factors that are calculated for a total of nine factors. The categories include pediatric at a non-Tier I PICU Facility, a pediatric at a Tier I PICU Facility and an adult. Within each category, the three factor calculations include a primary diagnosis of non-behavioral health with no presence of behavioral health, a primary diagnosis of non behavioral health with a secondary diagnosis of behavioral health and a primary diagnosis of behavioral health. For example, Tier I PICU

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Facilities treat higher acuity children and therefore have a higher expected rate of readmission than those children with the same diagnosis treated at the non-Tier I PICU Facilities. By applying this factor, it risk-adjusts the hospital's PPR rate to account for the variance in readmission rates for the different categories.

- 17) As of August 1, 2013, "Tier I Pediatric Intensive Care Unit" or "PICU" shall mean, a hospital that is either freestanding or has a Distinct Part Unit having pediatric trauma units and provides two or three of the following sets of procedures: pediatric transplants, Extracorporeal Membrane Oxygenation (ECMO), and complex pediatric cardiac surgeries.

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 PPR Chain may have one or more readmissions that are clinically related to the Initial Admission. The first readmission is within 30 days after the Initial Admission, but the 30 day timeframe begins again at the discharge of either the Initial Admission or the most recent readmission clinically related to the Initial Admission. For example, a patient is discharged after being admitted for back surgery and readmitted two weeks after the discharge for a post-operation infection that is clinically related to the back surgery. The 30 day period begins again at the discharge for the post-operation infection. However, if the patient is

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readmitted for a broken leg within 30 days after the post-operation infection, there is no clinical relationship and therefore not considered a PPR. Should a readmission occur within 30 days that is clinically related to the broken leg, then that would create a new PPR Chain separate from the back surgery.

- D) 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, certain HIV APR DRGs (listed in the version of the 3M definitions manual applicable to the State fiscal year in question), alcohol or drug detoxification, non-acute events (rehabilitation admissions), or, for hospitals defined in 89 Ill. Adm. Code ~~148.25(d)(4)-149.50(e)(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 Medicaid Managed Care Entity (MCE)~~Managed Care Organization (MCO)~~.
- D) As of August 1, 2013, effective for fiscal year 2014, admissions for children defined as less than the age of 19 that have a primary diagnosis at discharge for Behavioral Health. Children treated for an acute service, but who have a secondary diagnosis of Behavioral Health are still included in the analysis, but the Pediatric/Behavioral Health Factor is applied.
- 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 or

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transfers from one acute hospital to another. Non-events are ignored and are not considered to be readmissions.

- 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) State fiscal year 2013
 - A) 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.
 - B) 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 ~~148.25(a)~~148.458(a).
 - C) 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)(1)(B).
 - D) 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.
 - 2) Effective August 1, 2013 for State fiscal year 2014 and thereafter.
 - A) The Targeted Rate of Readmission for the Current Year 2014 shall be based on the inpatient hospital medical assistance services provided in the Data Year 2011 for admissions that occurred between July 1, 2010 and June 30, 2011. The Data Year will be

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updated one year for determining the Targeted Rate of Readmission for each Current Year thereafter.

- B) The average statewide expected rate of readmission will be multiplied by .85 for acute services and .90 for Behavioral Health Services. This multiplication factor sets a goal that is specific to each hospital that lowers the Target Rate of Readmission rather than maintaining the statewide average.
 - C) A Pediatric/Behavioral Health Factor is applied to those services provided at a Tier I PICU to account for the higher PPR rate for the higher acuity children.
 - D) Excess readmissions for each hospital shall be calculated by subtracting the actual number of PPR Chains from the targeted number of PPR Chains as adjusted in subsection (e)(2)(B) and (e)(2)(C).
 - E) In the event the actual number of PPR Chains for a hospital is lower than the targeted number of PPR Chains, the excess number of readmissions shall be set at zero.
- f) Payment Reduction Calculation for State fiscal year 2013
- 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 number of PPR Chains above the target as determined in subsection (e)(1)(C).
 - 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)(1)(B). 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) Effective August 1, 2013, Payment Penalty Calculation for State Fiscal Year 2014 and Thereafter
- 1) An average readmission penalty 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 penalty payments shall equal the average readmission payment per PPR Chain, as determined in subsection (g)(1) multiplied by the number of PPR Chains above the target as determined in subsection (e)(2)(D).
 - 3) The total annual payment penalty for each hospital shall be the lesser of:
 - A) The total excess readmission payments as determined in subsection (g)(2); or
 - B) The total inpatient medical assistance payments per hospital, including admissions that were excluded from the PPR analysis (that includes all static and assessment payments net of the annual assessment tax), multiplied by 3%.
 - 4) Prior to collection of the payment penalty, an analysis will be conducted of the Current Year data to determine if any of the payment penalty was cost avoided. Once the Current Year is complete and all inpatient hospital claims data has been received and adjudicated by the Department, the Department will calculate the hospital's Actual Rate of Readmission using the same version of the PPR software that was used to calculate the Base Year. A comparison of the Base Year to the Current Year will be done to see if hospitals were able to reduce their readmissions and their average cost per PPR Chain.
 - A) The payment penalty can be cost avoided in full if a hospital lowers its Actual Rate to at or below its Targeted Rate of Readmission.

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- B) Hospitals that did not meet their Targeted Rate of Readmission but lowered their Actual PPR rate can have a portion of their payment penalty cost avoided. In order to have a portion of the payment penalty cost avoided, hospitals must reduce the variance between their Actual Rate and their Targeted Rate of Readmission and lower their average medical assistance payment per PPR Chain for the Current Year.
 - C) Based on the analysis performed in subsection (g)(4)(B), hospitals that are able to reduce their readmissions compared to the Base Year will have the cost avoided amount deducted from their payment penalty.
 - D) Should a hospital have a higher rate of readmission when compared to the Base Year, the payment penalty will not be more than the original amount calculated.
 - E) If an aggregate application of the cost avoidance calculation shows that hospitals have reduced the cost of readmissions for the Current Year when compared to the Base Year by more than the total payment penalty owed by all hospitals, then payment penalties will not be charged to any hospital for that year. This aggregate calculation must factor in the hospitals that performed worse in the Current Year.
- 5) After the application of any cost avoidance pursuant to subsection (g)(4), hospitals will pay 50% of the remaining payment penalty to the Department. This amount shall be paid in 12 equal installments beginning on July 1, of the next fiscal year.
 - 6) Hospitals that are delinquent in paying any amounts due will have adjustments applied to future claims until the full amount of the payment penalty due has been recouped.

(Source: Amended at 38 Ill. Reg. 15527, effective July 2, 2014)

Section 152.350 Inpatient and Outpatient Rate Adjustments

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Notwithstanding anything to the contrary in 89 Ill. Adm. Code 140, 146, 148, 149 and 152, any updates to the system shall not result in any diminishment of the overall effective rate of reimbursement as of the implementation date of the new system (July 1, 2014). These updates shall not preclude variations in any individual component of the system or hospital rate variations. Nothing in 89 Ill. Adm. Code 140, 146, 148, 149 and 152 shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors including, but not limited to, number of individuals in the medical assistance program and severity of illness of the individuals.

(Source: Added at 38 Ill. Reg. 15527, effective July 2, 2014)

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- 1) Heading of the Part: Medicaid Community Mental Health Services Program
- 2) Code Citation: 59 Ill. Adm. Code 132
- 3)

<u>Section Numbers</u> :	<u>Adopted Action</u> :
132.25	Amendment
132.27	Amendment
132.30	Amendment
132.31	New Section
132.33	New Section
132.42	Amendment
132.44	Amendment
132.45	Repealed
132.47	Amendment
132.48	Amendment
132.50	Amendment
132.55	Amendment
132.80	Amendment
132.90	Amendment
132.91	Amendment
132.100	Amendment
- 4) Statutory Authority: Implementing and authorized by the Community Services Act [405 ILCS 30] and Section 15.3 of the Mental Health and Developmental Disabilities Administrative Act [20 ILCS 1705/15.3]
- 5) Effective Date of Rule: July 1, 2014
- 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, including any material 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*: August 16, 2013; 37 Ill. Reg. 13045

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- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: There were non-substantive changes made to this rule.
- 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 any emergency rule currently in effect? No
- 14) Are there any rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: This rulemaking is necessary to expand the granting of deemed status to consider Medicaid reform and interagency coordination of monitoring and oversight to reduce or eliminate redundant oversight of community contractors. The certification process is also being made clearer with the addition of two new Sections entitled Certification Review Cycle and Certification of New Sites or Services.
- 16) Information and questions regarding these adopted rules shall be directed to:
- Tracie Drew, Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Building, 3rd Floor
Springfield IL 62762
- 217/785-9772
- 17) Does this rulemaking require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code? No

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

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TITLE 59: MENTAL HEALTH
CHAPTER IV: DEPARTMENT OF HUMAN SERVICESPART 132
MEDICAID COMMUNITY MENTAL
HEALTH SERVICES PROGRAM

SUBPART A: GENERAL PROVISIONS

Section	Purpose
132.10	Purpose
132.15	Incorporation by Reference
132.20	Clients' Rights and Confidentiality (Repealed)
132.25	Definitions
132.27	Provider Qualifying Conditions
132.30	Application, Certification and Recertification Processes
132.31	Certification Review Cycle
132.33	Certification of New Sites of Services
132.35	Recertification and Reviews (Repealed)
132.40	Certification for Additional Medicaid Community Mental Health Services and/or New Site(s) (Repealed)
132.42	Post-Payment Review
132.44	Appeal of Post-Payment Review Findings
132.45	Compliance with Certification Requirements (Repealed)
132.47	Suspension of Certification
132.48	Reinstatement Following Suspension of Certification
132.50	Revocation of Certification
132.55	Appeal of Certification Decisions
132.58	Utilization Management by the Public Payer
132.60	Rate Setting

SUBPART B: PROVIDER ADMINISTRATIVE REQUIREMENTS

Section	Purpose
132.65	Organizational Requirements
132.70	Personnel and Administrative Recordkeeping
132.75	Program Evaluation (Repealed)
132.80	Fiscal Requirements

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132.85	Recordkeeping
132.90	Provider Sites
132.91	Accreditation
132.95	Utilization Review
132.100	Clinical Records
132.105	Continuity and Coordination of Services (Repealed)
132.110	Availability of Services (Repealed)
132.115	Provisions (Repealed)
132.120	Service Needs Evaluation (Repealed)
132.125	Treatment Plan Development and Modification (Repealed)
132.130	Psychiatric Treatment (Repealed)
132.135	Crisis Intervention (Repealed)
132.140	Day Treatment

SUBPART C: MENTAL HEALTH SERVICES

Section

132.142	Clients' Rights
132.145	General Provisions
132.148	Evaluation and Planning Services
132.150	Treatment Services
132.155	Family Intervention, Stabilization and Reunification Services (Repealed)
132.160	Provisions (Repealed)
132.165	Case Management Services
132.170	Rehabilitative Case Management Services (Repealed)
132.APPENDIX A	Medicaid Community Mental Health Services Application Components (Repealed)
132.APPENDIX B	Utilization Parameters (Repealed)
132.TABLE A	Mental Health Clinic Program Client Services (Repealed)
132.TABLE B	Rehabilitative Mental Health Services (Repealed)
132.TABLE C	Family Intervention, Stabilization and Reunification Services (Repealed)

AUTHORITY: Implementing and authorized by the Community Services Act [405 ILCS 30] and Section 15.3 of the Mental Health and Developmental Disabilities Administrative Act [20 ILCS 1705/15.3].

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SOURCE: Emergency rules adopted at 16 Ill. Reg. 211, effective December 31, 1991, for a maximum of 150 days; new rules adopted at 16 Ill. Reg. 9006, effective May 29, 1992; amended at 18 Ill. Reg. 15593, effective October 5, 1994; emergency amendment at 19 Ill. Reg. 9200, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16178, effective November 28, 1995; amended at 21 Ill. Reg. 8292, effective June 25, 1997; recodified from the Department of Mental Health and Developmental Disabilities to the Department of Human Services at 21 Ill. Reg. 9321; amended at 22 Ill. Reg. 21870, effective December 1, 1998; emergency amendment at 23 Ill. Reg. 4497, effective April 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 10205, effective August 23, 1999; amended at 24 Ill. Reg. 17737, effective November 27, 2000; amended at 26 Ill. Reg. 13213, effective August 20, 2002; amended at 28 Ill. Reg. 11723, effective August 1, 2004; amended at 31 Ill. Reg. 9097, effective July 1, 2007; emergency amendments at 31 Ill. Reg. 10159, effective July 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 15805, effective November 8, 2007; amended at 32 Ill. Reg. 9981, effective July 1, 2008; emergency amendment at 35 Ill. Reg. 1128, effective January 1, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7719, effective April 28, 2011; amended at 35 Ill. Reg. 8860, effective May 26, 2011; amended at 36 Ill. Reg. 18582, effective December 13, 2012; amended at 38 Ill. Reg. 15550, effective July 1, 2014.

SUBPART A: GENERAL PROVISIONS

Section 132.25 Definitions

For the purposes of this Part, the following terms are defined:

Accessibility – Compliance with all appropriate provisions of the Americans With Disabilities Act (ADA) (42 USC 12101), as amended, and section 504 of the Rehabilitation Act of 1973 (29 USC 794). No otherwise qualified disabled individual solely by reason of a disability, shall be excluded from participation in, be denied the benefits of or be subjected to discrimination in programs, services or activities sponsored by the ~~Provider~~provider. The ~~Provider~~provider shall make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless it can demonstrate that making the modifications would fundamentally alter the nature of the services, program or activity. The ~~Provider~~provider shall communicate this policy to all visitors, recipients of services, potential recipients of services, and employees. This includes the extent to which a ~~Provider~~provider has adapted sites where services are provided to render its physical building

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elements, parking lot, entry, egress, restrooms, circulation paths, telecommunications and technology accessible to persons with disabilities in accordance with the ADA, section 504, and the most recent standards identified in the Illinois Accessibility Code (71 Ill. Adm. Code 400) and/or ADA Accessibility Guidelines, whichever standard is more stringent, as well as the Provider's provider's reasonable modification for the delivery of services to otherwise eligible Clientselients for whom a site is inaccessible.

Activity – Action taken on behalf of Clientselients to facilitate receipt of services.

Admission Note – A written report of an initial assessment and treatment plan that initiates Part 132 services for Clientselients who are admitted to a specialized substitute care living arrangement or for the Clientelient who does not have a completed mental health assessment and is admitted to Assertive Community Treatment (ACT) services or a residential facility designated by the Public Payerpublic payer for the purpose of stabilizing a crisis.

Adult – An individual who is 18 years of age or older or a person who is emancipated pursuant to the Emancipation of Mature Minors Act [750 ILCS 30].

Applicant – An entity that seeks certification to provide Medicaid community mental health services under this Part.

Assertive Community Treatment or ACT – An intensive integrated rehabilitative crisis, treatment and rehabilitative support service for adults (18 years of age and older) provided by an interdisciplinary team to individuals with serious and persistent mental illness or co-occurring mental health and alcohol/substance abuse disorders. The service is intended to promote symptom stability and appropriate use of psychotropic medication, as well as restore personal care, community living and social skills. ACT is further defined in Section 132.150(h).

Certification Certificate – A document by the Certifying State Agency that indicates that a stated Provider is certified to provide specific Part 132 services at specified sites.

Certified Family Partnership Professional or CFPP – An individual who is certified and in good standing as a Family Partnership Professional by the Illinois Certification Board, doing business as (dba) the Illinois Alcohol and Other Drug

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Abuse Professional Certification Association, Inc. (IAODAPCA).

Certified Recovery Support Specialist or CRSS – An individual who is certified and in good standing as a Recovery Support Specialist by [the Illinois Certification Board, dba IAODAPCA](#).

Certifying State Agency – Departments responsible for determining and monitoring compliance with this Part: Department of Healthcare and Family Services, Department of Human Services or Department of Children and Family Services.

CGAS – The Children's Global Assessment Scale as published in the Archives of General Psychiatry, Volume 40, November 1983, pp. 1228-1231.

Client – An individual who is Medicaid-eligible and is receiving Medicaid community mental health services.

Clinical Experience – Work or volunteer or internship experience providing mental health services or supports supervised by a Mental Health Professional level professional.

CMMS – Centers for Medicare and Medicaid Services. A federal agency within the U.S. Department of Health and Human Services with responsibility for Medicare, Medicaid, State Children's Health Insurance (SCHIP), Health Insurance Portability and Accountability Act (HIPAA), and Clinical Laboratory Improvement Amendments (CLIA).

Collateral – A person with a relationship to a [Clientelient](#) and who is important in the treatment or recovery goals of the [Clientelient](#) or who is a resource to assist the [Clientelient](#) in meeting treatment or recovery goals.

[Community Support Service or CS Service – Mental health rehabilitation services and supports for children, adolescents, families and adults necessary to assist clients in achieving rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions that facilitate illness self-management, skill building, identification and use of natural supports, and use of community resources. CS services help clients develop and practice skills in their home and community. CS service is further defined in Section 132.150\(e\).](#)

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Community Support – Residential Service or CSR Service – Mental health rehabilitation services and supports for children, adolescents and adults necessary to assist individuals in achieving rehabilitative, resiliency and identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources for individuals who reside in sites designated by the Public Payer. CSR service is further defined in Section 132.150(f).

Community Support – Team Service or CST Service – Mental health rehabilitation services and supports available 24 hours per day and 7 days per week for children, adolescents, families and adults to decrease hospitalization and crisis episodes and to increase community functioning in order for the client to achieve rehabilitative, resiliency and recovery goals. The service consists of interventions delivered by a team that facilitates illness self-management, skill building, identification and use of adaptive and compensatory skills, identification and use of natural supports, and use of community resources. CST service is further defined in Section 132.150(g).

Confidentiality Act – The Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110].

Contract – For purposes of this Part, a written agreement between the applicant/~~Provider~~provider and a ~~Public Payer~~public payer.

Co-occurring – Co-existing mental health and substance use disorders or developmental disabilities. Individuals eligible to receive services under this Part must have a diagnosis of mental illness.

Credential – Designation of LPHA, QMHP, MHP, RSA or professional designation as included in this Part.

Crisis Intervention Services – Interventions to stabilize a Client in a psychiatric crisis to avoid more restrictive levels of treatment and that have the goal of immediate symptom reduction, stabilization and restoration to a previous level of role functioning. A crisis is defined as a deterioration in the level of role functioning of the Client within the past 7 days or an increase in acute symptomatology. Crisis intervention services are further defined in Section

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132.150(b).

Day – A calendar day unless otherwise indicated.

DCFS – The Illinois Department of Children and Family Services.

DHS – The Illinois Department of Human Services.

DSM-IV – The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (1994) or DSM-IV-TR (2000), American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, Virginia 22209-3901.

Enrollment – The official enrollment of a ~~Provider~~provider in the medical assistance program by HFS on determination of compliance with 89 Ill. Adm. Code 140.11.

Family – A basic unit or constellation of one or more adults and children, foster or adoptive parents and children, and private individual guardians.

~~Family Resource Developer – A parent or care-giver who has navigated multiple child-serving systems on behalf of a child or adolescent with Severe Emotional Disturbance (SED) as a consumer of the mental health system. The individual has a high school diploma or equivalency and has demonstrated the ability to work collaboratively with families, children, agency staff and other providers in the community.~~

Focus Review – A follow-up review done to assure implementation of an accepted Plan of Correction. A focus review looks at the violations found during a full review and addressed in a required Plan of Correction to assure implementation of the Plan of Correction.

GAF – The Global Assessment of Functioning Scale contained in the DSM-IV.

Guardian – The court-appointed guardian or conservator of the person under the Probate Act of 1975 [755 ILCS 5] or a temporary custodian or guardian of the person of a child appointed by an Illinois juvenile court or a legally-appointed guardian or custodian or other party granted legal care, custody and control over a minor child by a juvenile court of competent jurisdiction located in another state

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whose jurisdiction has been extended into Illinois via the child's legally authorized placement in accordance with the applicable interstate compact. (~~See the~~The Juvenile Court Act of 1987 [705 ILCS 405] ~~and the~~ Interstate Compact on the Placement of Children [45 ILCS 15].)

Healthy Kids Screen – A mental health screening done as part of an HFS Healthy Kids periodic screening (89 Ill. Adm. Code 140.485).

HFS – The Illinois Department of Healthcare and Family Services.

HIPAA – The Health Insurance Portability and Accountability Act (42 USC 1320 et seq.) (45 CFR 160 and 164 (2003)).

HITECH – Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), P.L. 111-5 (Feb. 17, 2009).

ICD-9-CM – International Classification of Diseases, 9th Revision, Clinical Modification (Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244-1850 (2008)).

Intervention – A deliberate interaction between staff and one or more ~~Client~~clients or a ~~Client~~client's collateral for the purpose of alleviating the ~~Client~~client's symptoms of mental illness and improving the ~~Client~~client's level of functioning.

ITP – Individual treatment plan.

Level of Role Functioning – Refers to the ~~Client~~client's abilities in critical areas such as vocational, educational, independent living, self-care, and social and family relationships. To assess the severity of the impairment in role functioning, scales approved for use include, but are not limited to, the GAF Scale or the CGAS Scale.

Licensed Clinician – An individual who is either a licensed practitioner of the healing arts (LPHA); a licensed social worker (LSW) possessing at least a master's degree in social work and licensed under the Clinical Social Work and

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Social Work Practice Act [225 ILCS 20] with specialized training in mental health services or with at least two years experience in mental health services; a licensed professional counselor (LPC) possessing at least a master's degree and licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107] with specialized training in mental health services or with at least two years experience in mental health services; a registered nurse (RN) licensed under the Nurse Practice Act [225 ILCS 65] with at least one year of clinical experience in a mental health setting or who possesses a master's degree in psychiatric nursing; or an occupational therapist (OT) licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of clinical experience in a mental health setting.

Licensed Practitioner of the Healing Arts or LPHA – An Illinois licensed health care practitioner who, within the scope of State law, has the ability to independently make a clinical assessment, certify a diagnosis and recommend treatment for persons with a mental illness and who is one of the following: a physician; an advanced practice nurse with psychiatric specialty licensed under the Nurse Practice Act [225 ILCS 65]; a clinical psychologist licensed under the Clinical Psychologist Licensing Act [225 ILCS 15]; a licensed clinical social worker (LCSW) licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20]; a licensed clinical professional counselor (LCPC) licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]; or a licensed marriage and family therapist (LMFT) licensed under the Marriage and Family Therapist Licensing Act [225 ILCS 55] and 68 Ill. Adm. Code 1283.

Medicaid – Medical assistance authorized by HFS under the provisions of the Illinois Public Aid Code [305 ILCS 5/Art. V], the Children's Health Insurance Program Act [215 ILCS 106] and Titles XIX and XXI of the Social Security Act (42 USCA 1396 and 1397aa).

Medical Necessity or Medically Necessary – An LPHA has determined through assessment that a Client/ient has a diagnosis of mental illness or serious emotional disorder as defined in the ICD-9-CM or DSM-IV that has resulted in a significant impairment in the Client's/ient's level of functioning in at least one major life functional area and needs one or more mental health services that are identified in the Mental Health Assessment and ITP to stabilize the Client's/ient's functioning, or to restore or rehabilitate the Client/ient to a maximum level of

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life functioning. For ~~Client~~clients under the age of 21, medical necessity or medically necessary may additionally mean that the ~~Client~~client has more than one documented criteria of a mental illness or serious emotional disorder as listed in the DSM-IV that is likely to impact the ~~Client's~~client's level of role functioning across critical life areas and needs a Medicaid reimbursable Part 132 mental health service recommended by the completion of an approved Healthy Kids screen by a physician or the completion of a Mental Health Assessment and included in an ITP that could not have been omitted without adversely affecting the ~~Client's~~client's level of functioning.

Mental Health Assessment or MHA – A Mental Health Assessment required by Section 132.148(a) to assess the need for Part 132 services.

Mental Health Intensive Outpatient Services – Scheduled group therapeutic sessions made available for at least 4 hours per day, 5 days per week. Mental health intensive outpatient services are further defined in Section 132.150(j).

Mental Health Professional or MHP – An individual who provides services under the supervision of a Qualified Mental Health Professional~~qualified mental health professional~~ and who possesses: a bachelor's degree in counseling and guidance, rehabilitation counseling, social work, education, vocational counseling, psychology, pastoral counseling, family therapy, or related human service field; a bachelor's degree in any other field with two years of supervised clinical experience in a mental health setting; a practical nurse license under the Nurse Practice Act [225 ILCS 65]; a certificate of psychiatric rehabilitation from a DHS-approved program plus a high school diploma or GED plus 2 years experience in providing mental health services; a recovery support specialist certified from, and in good standing with, the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc.; a family partnership professional certificate from and in good standing with the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc.; an occupational therapy assistant licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of experience in a mental health setting; or a minimum of a high school diploma or GED and 5 years supervised clinical experience in mental health or human services. A supervised internship in a mental health setting counts toward the experience in providing mental health services. Any individual meeting the minimum credentials for an LPHA or QMHP under this Part is deemed to also meet the credentialing requirements of an MHP. Any individual employed as an

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MHP prior to July 1, 2013 may continue to be so designated unless employment changes.

Mental Health Setting – A location, public or private, in a group or individual practice, in a mental health center, hospital or clinic where services intended to reduce symptoms of mental illness are provided to persons with mental illness.

Mental Illness – A mental or emotional disorder diagnosis contained in the DSM-IV or ICD-9-CM or, for ~~Client~~~~clients~~ under age 21, symptoms of mental illness that are likely to impact the ~~Client's~~~~client's~~ level of role function across critical life areas, authorized by the ~~Public Payer~~~~public payer~~ funding the services under this Part and the condition that will be the main focus of treatment for services under this Part. Mental illness does not include organic disorders such as dementia and those associated with known or unknown physical conditions such as hallucinosis, amnesic disorder and delirium; psychoactive substance induced organic mental disorders; and mental retardation or psychoactive substance use disorders.

Natural Setting – A setting where an individual who has not been diagnosed with a mental illness typically spends time, including home, school, work, churches, community centers, libraries, parks, recreation centers, etc. These sites are not licensed, certified or accredited as a treatment setting nor typically identified as treatment sites.

Natural Support – Persons identified by the ~~Client~~~~client~~ who are not paid to provide support, e.g., family, friends, pastor.

Notice of Deficiencies – A written document that specifies the standards within this Part with which the Provider is not compliant.

Notice of Non-certification – A written document that notifies the applicant or Provider that the Certifying State Agency is not issuing a Certificate of Certification.

Notice of Suspension from Billing – The report generated under Section 132.42(f) following a post-payment review that details the findings for the review when less than 50% of the billings have been found to be substantiated.

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Notice of Unsubstantiated Billings – The report generated under Section 132.42(c) following a post-payment review that details the findings of the review.

Off-site – Locations other than those considered on-site.

On-site – Location that is a certified ~~Provider~~provider site as described in Section 132.90 and the surrounding ~~Provider~~provider owned, leased or controlled property and buildings and adjacent parking areas. Additionally, any service that is provided via telephone or video or that is provided to a ~~Client~~client in a staff person's office in a certified site is considered on-site.

One Year Experience – A period of time consisting of at least 1,500 work hours.

Original Signature – A signature affixed to any document that is made by the person to whom the signature belongs, either in ink or via electronic means compliant with Section 132.85(f).

Part 132 Services – The community mental health services described in this Part.

Physician – A physician licensed under the Medical Practice Act of 1987 [225 ILCS 60] to practice medicine in all its branches.

Plan of Correction – Plan submitted in response to findings from the Certifying State Agency of non-compliance resulting from a certification or post-payment review that specifies actions the Provider or applicant will take to come into compliance with this Part by correcting the cited violations. The Plan of Correction will include the time frame for compliance and how ongoing compliance will be monitored and assured.

Provider – An organization certified to provide Medicaid community mental health services in accordance with this Part that is a sole proprietorship, partnership, limited liability corporation, unit of local government, or corporation, public or private, either for profit or not for profit.

Psychosocial Rehabilitation Service or PSR Service – Facility-based rehabilitative skill-building services for adults age 18 and older with serious mental illness or co-occurring psychiatric disabilities and addictions. The PSR interventions focus on identification and use of recovery tools and skill building to facilitate

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independent living and adaptation, problem solving and coping skills development. PSR service is further defined in Section 132.150(i).

Psychotropic Medication – Medication whose use for antipsychotic, antidepressant, antimanic, antianxiety, behavioral modification or behavioral management purposes is listed in the AMA Drug Evaluations or Physician's Desk Reference, or that is administered for any of these purposes.

Psychotropic Medication Administration Service – Consists of preparing the Client and the medication for administration, administering psychotropic medications, observing the Client for possible adverse reactions, and returning the medication to proper storage. Psychotropic medication administration service is further defined in Section 132.150(c)(3).

Psychotropic Medication Monitoring Service – Includes observation and evaluation of target symptom response, adverse effects, including tardive dyskinesia screens, and new target symptoms or medication. This may include discussing laboratory results with the Client. Psychotropic medication monitoring service is further defined in Section 132.150(c)(4).

Psychotropic Medication Training Service – Includes training the Client or the Client's family or guardian to administer the Client's medication, to monitor proper levels and dosage, and to watch for side effects. Psychotropic medication training service is further defined in Section 132.150(c)(5).

Public Payer – A State agency or a unit of local government that is responsible for payment for services under this Part provided to a ~~Client~~ pursuant to a contract with the ~~Provider~~.

Qualified Mental Health Professional or QMHP – One of the following:

A licensed social worker (LSW) possessing at least a master's degree in social work and licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20] with specialized training in mental health services or with at least 2 years experience in mental health services;

A licensed professional counselor possessing at least a master's degree and licensed under the Professional Counselor and Clinical Professional

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Counselor Licensing Act [225 ILCS 107] with specialized training in mental health services or with at least two years experience in mental health services;

A registered nurse (RN) licensed under the Nurse Practice Act [225 ILCS 65] with at least one year of clinical experience in a mental health setting or who possesses a master's degree in psychiatric nursing;

An occupational therapist (OT) licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of clinical experience in a mental health setting; or

An individual possessing at least a master's degree in counseling and guidance, rehabilitation counseling, social work, vocational counseling, psychology, pastoral counseling, or family therapy or related field, who has successfully completed a practicum or internship that included a minimum of 1,000 hours of supervised direct service in a mental health setting, or who has one year of clinical experience under the supervision of a QMHP.

Any individual meeting the minimum credentials for a LPHA under this part is deemed to also meet the credentialing requirements of a QMHP.

Rehabilitative Services Associate or RSA – An RSA must be at least 21 years of age, be a high school graduate or have a GED certificate, have demonstrated skills in the field of services to adults or children, have demonstrated the ability to work within the ~~Provider's~~ structure and accept supervision, and have demonstrated the ability to work constructively with ~~Clients~~, treatment resources and the community. Any individual meeting the minimum credentials for an MHP, QMHP or LPHA under this Part is deemed to also meet the credentialing requirements of an RSA. Any individual employed as an RSA prior to July 1, 2013 may continue to be so designated unless employment changes.

Screening, Assessment and Support Services or SASS – A program of intensive mental health services provided by an agency certified to provide Part 132 services and under contract to provide screening, assessment and support services to children with a mental illness or emotional disorder who are at risk for psychiatric hospitalization.

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Section 504 – Section 504 of the Rehabilitation Act of 1973 (29 USC 794).

Specialized Substitute Living Arrangement – A living arrangement providing services to a ~~Client~~^{client} supervised by a ~~Provider~~^{provider} licensed under the Child Care Act of 1969 [225 ILCS 10] or any comparable Act in another state when the ~~Provider~~^{provider} is under contract to the State agency.

State Agency – Department of Healthcare and Family Services, Department of Human Services, or Department of Children and Family Services.

State Medicaid Agency – The Illinois Department of Healthcare and Family Services.

Suspended Certificate – A certificate that is temporarily inactive due to Certifying State Agency action.

Therapy/Counseling Service – A treatment modality that uses interventions based on psychotherapy theory and techniques to promote emotional, cognitive, behavioral or psychological changes as identified in the ITP. Therapy/counseling service is further defined in Section 132.150(d).

Unit of Local Government – A county, municipal corporation, or other local government entity organized under the laws of the State of Illinois that, pursuant to an executed intergovernmental agreement with HFS, has agreed to pay for Medicaid community mental health services.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.27 Provider Qualifying Conditions

- a) A ~~Provider~~^{provider} shall, at a minimum, directly provide mental health assessment, ITP development, review, modification (see Section 132.148(c)) and at least one additional Part 132 mental health service. Directly provided means that the QMHP and LPHA who signed the ~~Mental Health Assessment~~^{mental health assessment} and ITP are employed by or contractual employees of the ~~Provider~~^{provider}. The ~~Public Payer~~^{public payer} may waive the requirement of at least one additional Part 132 mental health service if it deems that such a waiver

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increases the availability of mental health services to Medicaid-eligible Client~~clients~~.

- b) A Provider ~~provider~~ may not subcontract for services authorized by this Part. If a Provider is unable to provide a service needed by a Client, the Provider may refer the Client to another certified Provider if another certified Provider is available and if the Client agrees to the referral. ~~All subcontractors must be certified to participate in the Illinois Medical Assistance program and enrolled as a provider with HFS. There shall be a written agreement between the provider and the subcontractor that defines their contractual agreement and assures the subcontractor's compliance with applicable service provisions of Subpart C. All subcontracts must be approved by and on file with the State agency and, when applicable, the public payer.~~ For purposes of this subsection, a contractual employee or an individual on contract is not considered to be a subcontractor.
- c) Billings for services rendered under this Part shall be submitted only by the Provider that directly provided the service and only to the Public Payer that is funding the service. ~~A provider subcontracted for services authorized under this Part shall comply with accessibility requirements in accordance with the Americans With Disabilities Act (ADA) (42 USC 12101), as amended, section 504 of the Rehabilitation Act of 1973 (29 USC 794), and standards identified in the current Illinois Accessibility Code (71 Ill. Adm. Code 400) and/or ADA Accessibility Guidelines, whichever standard is more stringent.~~

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.30 Application, Certification and Recertification Processes

- a) ~~A State agency, subject to an executed interagency agreement with HFS in its capacity as the Medicaid State agency for Illinois, is authorized to perform the functions ascribed under this Part.~~
- ab) Any entity having a contract with a State agency for the provision of mental health services, other than hospital inpatient or hospital outpatient psychiatric services, with DCFS for the provision of child welfare services, with DCFS or DHS for the provision of youth services, or with DOC for the provision of youth treatment, rehabilitative or transitional services may apply for certification as a Provider~~provider~~. Applicants who meet the requirements of this Part will be

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certified to provide Medicaid community mental health services by one of the State agencies and enrolled as a Provider~~provider~~ in the Illinois medical assistance program by HFS pursuant to 89 Ill. Adm. Code 140.11. Providers will be certified by, and subject to, Medicaid certification review by only one State agency. Providers who are certified to provide comparable Medicaid services in other states may apply to a State agency for reciprocity consideration and enrollment. Providers applying for reciprocity consideration and enrollment will be subject to the same standards as those Providers~~providers~~ applying for certification under this Part.

b) Applications may be obtained by submitting a request in writing to:

Illinois Department of Human Services
Bureau of Accreditation, Licensure and Certification
401 North Fourth Street
Springfield, Illinois 62702

or

Illinois Department of Children and Family Services
Office of Medicaid Certification
406 East Monroe Street
Springfield, Illinois 62701

c) The applicant shall submit to DHS or DCFS a completed "Application for Certification of Medicaid Community Mental Health Services Programs" with all of the required accompanying components, as specified on the application form. An applicant shall submit its application to the Certifying State Agency that it intends to contract with for Part 132 services.

- 1) If an applicant intends to contract for Part 132 services with more than one State agency, the applicant shall submit its application to the State agency that provides the most funding for those Medicaid community mental health services.
- 2) If the funding from the Certifying State Agencies is equal, the applicant shall submit the application to DHS.

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- 3) The application shall include information including, but not limited to:
- A) Applicant name and business status, including evidence of being in good standing to do business in the State of Illinois~~corporate status~~;
 - B) List of services the applicant is requesting be certified;
 - C) Description of population to be served, including age groups;
 - D) Description of how the Clients~~clients~~ will actively participate in the development of their ITP and ongoing services;
 - E) Description of each service to be certified, how it will be provided by the applicant, and evidence of applicant's ability to provide each service in compliance with this Part~~how each service to be certified fits into the programs of the applicant and other evidence of compliance with specific service definitions (see Subpart C)~~;
- i) For Psychosocial Rehabilitation, the applicant must submit a work week schedule for each site, including the name of the staff at each location who has co-occurring training or experience;
- ii) For Assertive Community Treatment, the applicant must submit the names of staff on each team, indicating their credentials and their role on the team, e.g., CRSS, experience in co-occurring disorders, and the time worked each week; and
 - iii) For Community Support Team, the applicant must submit the names of staff on each team, indicating their credentials and their role on the team, and the amount of time that each staff works on the team weekly;
- F) List of sites to be certified and the services to be provided at each site;
- G) The address of all accessible sites and the plan for modifications

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needed for persons with disabilities;

~~H) Fire clearance, electrical and plumbing clearances for each site, pursuant to Section 132.90;~~

~~H) The address of all accessible sites;~~

I) A staffing roster including staff qualifications and supervisory responsibilities for each of the sites; and

J) Policies required in Subpart B of this Part ~~on confidentiality and third-party payments;~~

~~K) Utilization review plan;~~

~~L) Medicare certification status; and~~

~~M) Methods used to facilitate communication access for persons with disabilities, alternative formats and the provisions of qualified, licensed sign language interpreters to be available upon request.~~

de) If the application form and all of the required components are in compliance with this Part, the Certifying State Agency shall issue to the Provider a Certification Certificate for the Medicaid Community Mental Health Services Program.

1) The Certifying State Agency shall issue the Certification Certificate within 30 days after the Certifying State Agency receives the completed application and all required components. The effective date of certification shall be the date that the application was approved. The Certifying State Agency shall also send the Medicaid enrollment forms to the Provider. The Provider shall complete the enrollment forms for each certified site and submit them to HFS to enroll the sites in the Illinois medical assistance program (89 Ill. Adm. Code 140). An applicant that submits an application that is not in compliance with this Part shall receive a Notice of Deficiencies. The Certifying State Agency shall issue the Notice of Deficiencies within 30 days after receiving the application. If the applicant intends to proceed with applying for Medicaid certification,

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~~the applicant shall submit corrected documentation to address all of the deficiencies within 30 days after the date on the Notice of Deficiencies. The applicant shall submit the corrected documentation to the Certifying State Agency that received the application and issued the Notice of Deficiencies.~~

- 2) ~~The Certification Certificate shall be in effect for three years. State agency shall issue the certificate within 30 days after the Certifying State Agency receives the completed application and all required components, including corrected documentation, if applicable. The effective date of certification shall be the date that the application or, if required, corrected documentation was approved. The Certifying State Agency shall also send the Medicaid enrollment forms to the provider. The provider shall complete the enrollment forms for each certified site to enroll those sites in the Illinois medical assistance program.~~
- 3) ~~The Provider shall deliver only mental health services under this Part for which it is certified. If the applicant fails to submit corrected documentation that demonstrates compliance with this Part within 30 days after the date of the Notice of Deficiencies, the Certifying State Agency shall issue a notice of noncertification.~~
- 4) ~~Any changes during the certification period that affect the ability of the Provider to deliver services in compliance with the requirements of this Part shall be reported to the Certifying State Agency within 30 days after occurrence. The applicant may reapply by submitting a complete application packet to the Certifying State Agency.~~
- 5) ~~A Provider is expected to provide Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT), Community Support Residential (CSR) and Community Support Team (CST) services as described in Section 132.150 within 90 days after being notified of certification for the services. If the service is not implemented within 90 days, the Provider must show compliance with the requirements in Section 132.30(c)(3)(E) before the Part 132 services can be provided.~~
- 6) ~~If a Provider has been certified for PSR, ACT, CSR or CST services and decides to no longer provide those services, the Provider shall notify the~~

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Certifying State Agency at least 60 days prior to discontinuing the services. The service may be subject to removal from the certificate. Prior to discontinuing the service, the Provider shall submit a plan to the Certifying State Agency for transitioning Clients to other services or to other Providers.

7) The Provider shall submit team rosters for ACT and CST services upon Public Payer request.

ef) If the application form and all of the required components are not in compliance with this Part, the Certifying State Agency shall issue a Notice of Deficiencies within 30 days after receiving the application. Certification shall be for 3 calendar years.

1) If the applicant intends to proceed with applying for Medicaid certification, the applicant shall submit corrected documents to address all of the deficiencies by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies. The applicant shall submit the corrected documents to the Certifying State Agency that received the application and issued the Notice of Deficiencies. A provider shall deliver only mental health services under this Part for which it is certified.

2) If the corrected documentation is found to address all of the deficiencies included in the Notice of Deficiencies, then the Certifying State Agency shall proceed with all requirements identified in Section 132.30(d). Any changes during the certification period that affect the ability of the provider to deliver services in compliance with the requirements of this Part shall be reported to the Certifying State Agency.

f) If the applicant fails to submit corrected documentation that demonstrates compliance with this Part by the due date indicated on the Notice of Deficiencies, the Certifying State Agency shall issue a Notice of Non-certification. The applicant may reapply by submitting a complete application packet to the Certifying State Agency.

3) A provider is expected to provide Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT), Community Support Residential

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~~(CSR) and Community Support Team (CST) services within 90 days after being notified of certification for the services. If the service is not implemented within 90 days, the provider must show compliance with the requirements in subsection (p) before the Part 132 services can be provided.~~

- ~~4) If a provider has been certified for PSR, ACT, CSR or CST and decides to no longer provide the services, the provider shall notify the Certifying State Agency at least 60 days prior to discontinuing the services. The service may be subject to removal from the certificate. Prior to discontinuing the service, the provider shall provide a plan for transitioning consumers to other services or to other providers.~~
- ~~5) The provider shall submit team rosters for ACT and CST upon public payer request.~~
- g) Within 14 months after the date of initial certification, the Certifying State Agency shall conduct a review.
 - ~~1) At the review, the Certifying State Agency shall evaluate the provider's compliance with this Part.~~
 - ~~2) If no deficiencies are noted at the review, the Certifying State Agency shall notify the provider of the results within 30 days after the completion of the review. Compliance reviews for recertification shall be conducted on or about the expiration date of the current certification period.~~
 - ~~3) If deficiencies are noted at the review, the Certifying State Agency shall report those deficiencies to the provider during an exit conference. The Certifying State Agency shall also issue a Notice of Deficiencies to the provider within 30 days after the completion of the review.~~
 - ~~4) If the Certifying State Agency issues a Notice of Deficiencies to the provider, the provider shall respond with a Plan of Correction pursuant to Section 132.45(a). The Plan of Correction shall address all of the deficiencies listed on the Notice of Deficiencies. The Plan of Correction must identify the actions that have been, or will be, taken to comply with this Part and the timeframes for implementing the corrective actions.~~

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~~Unless otherwise specified, the timeframes for implementing corrective actions must follow the requirements specified in Section 132.45. The provider must submit this Plan of Correction to the Certifying State Agency by the due date written on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies.~~

- ~~A) Providers that submit a Plan of Correction approved by the Certifying State Agency shall be notified of the approval. The Certifying State Agency shall notify the provider of the approval within 30 days after the Certifying State Agency receives the provider's Plan of Correction. The Certifying State Agency shall verify the provider's implementation of the Plan of Correction at the next review. If a Plan of Correction was required, the next review shall occur within 14 months after the date the Plan of Correction was approved. If the findings at the next review indicate that a provider has failed to implement a Plan of Correction, as evidenced by less than 50% of the items on the Notice of Deficiencies improving in their compliance percentage, the Certifying State Agency may revoke the provider's certification.~~
- ~~B) If a provider submits a Plan of Correction that does not address the deficiencies noted during a review pursuant to subsection (g)(4), the Certifying State Agency shall notify the provider within 30 days after receipt of the provider's Plan of Correction. The provider shall submit a revised Plan of Correction that addresses the deficiencies within 10 days after the date they were notified of the unacceptable Plan of Correction. The Certifying State Agency may revoke the provider's certification if the provider fails to submit an acceptable revised Plan of Correction within 10 days after the date of notification.~~
- ~~C) The Certifying State Agency may revoke a provider's certification if the provider fails to submit a Plan of Correction for deficiencies noted during a review by the due date written on the Notice of Deficiencies.~~
- ~~D) The Certifying State Agency may revoke a provider's certification if the provider shows a consistent failure to correct deficiencies and~~

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~~maintain those corrections by scoring 74% or less during two consecutive recertification reviews, as described in Section 132.45(a).~~

- ~~h) Compliance reviews for recertification shall be conducted on or about the expiration date of the current certification period. If the Certifying State Agency fails to conduct a compliance review for certification before the expiration of the current certification period, the certification shall remain valid until completion of the compliance review. Subsequent compliance reviews shall follow the process outlined in subsection (g).~~
- ~~i) The Certifying State Agency, HFS, or their respective agents, shall be granted access to all provider sites. All records shall be made available to the Certifying State Agency, HFS, or their respective agents, on request during the initial certification review, recertification reviews, post payment reviews and any other compliance reviews for services delivered under this Part. Access to records shall occur in accordance with the Confidentiality Act.~~
- ~~j) An applicant/provider who has been decertified by Medicare shall not be eligible for certification under this Part.~~
- ~~k) When a decision is made to deny certification of an applicant or recertification of a provider, the applicant/provider may appeal the decision and request a hearing in accordance with Section 132.55 of this Part and Section 10-25 of the Illinois Administrative Procedure Act [5 ILCS 100/10-25].~~
- ~~l) Following a review, a provider shall be notified of its level of compliance with this Part as specified in Section 132.45.~~
- ~~m) The findings from a review shall be placed in one of the levels of compliance as described in Section 132.45.~~
- ~~n) Providers that seek certification for new sites shall submit the following documentation to the Certifying State Agency:
 - ~~1) A clearance letter from the Office of the State Fire Marshal or approved local fire authority, dated within the preceding 12 months, stating that each additional site complies with local and State fire safety ordinances~~~~

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~~and codes pursuant to Section 132.90. For providers certified by DHS, the clearance letter must come from the Office of the State Fire Marshal only.~~

- ~~2) A signed statement from a licensed plumber or licensed architect, dated within the preceding 12 months, stating that each additional site complies with applicable plumbing codes pursuant to Section 132.90.~~
 - ~~3) A signed statement from an electrician or licensed architect, dated within the preceding 12 months, stating that each additional site complies with applicable electrical codes pursuant to Section 132.90.~~
 - ~~4) A signed statement from the provider, dated within the preceding 12 months, attesting to compliance with requirements of physical accessibility standards pursuant to Section 132.90.~~
 - ~~5) A list of the Part 132 services that will be provided at the site.~~
- ~~o) Providers that seek certification for additional Part 132 services shall submit a description of the additional services, including evidence of compliance with specific service definitions in this Part, and the sites where the services will be delivered. The description shall state how the additional services will be provided within the provider's program and shall include a listing of the LPHAs and QMHPs who will be responsible for directing the services. The provider shall submit the documentation for certification of additional services to the Certifying State Agency.~~
 - ~~p) Additional sites or services must be approved by the Certifying State Agency before the additional sites or services may be considered for certification.~~
 - ~~q) [Approved](#) additional sites or services shall be indicated on a revised certificate. If additional sites are certified, the provider shall enroll those sites in the Illinois medical assistance program. The addition of sites or services will not alter the expiration date of the certificate.~~
 - ~~r) The Certifying State Agency shall survey any additional sites or services for compliance with this Part during the next review.~~

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

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Section 132.31 Certification Review Cycle

- a) Initial Certification Review
Within 14 months after the date of the approval of the application for certification, the Certifying State Agency shall conduct an initial on-site certification review.
- 1) At the review, the Certifying State Agency shall evaluate the Provider's compliance with this Part and note the Provider's level of compliance as follows:
- A) Level 1 – Compliant: 90-100% Compliance
- i) Providers who achieve Level 1 will be considered to be in good standing with the Certifying State Agency.
- ii) The Certifying State Agency shall report any deficiencies to the Provider during an exit conference. The Certifying State Agency shall issue a Notice of Deficiencies to the Provider within 30 days after the completion of the review.
- iii) The Provider will not be required to submit a Plan of Correction in response to the Notice of Deficiencies.
- B) Level 2 – Substantially Compliant: 75-89% Compliance
- i) Providers who achieve Level 2 will be considered to be in good standing with the Certifying State Agency.
- ii) The Certifying State Agency shall report any deficiencies to the Provider during an exit conference. The Certifying State Agency shall issue a Notice of Deficiencies to the Provider within 30 days after the completion of the review.
- iii) The Provider shall submit a written Plan of Correction to address each of the deficiencies included in the Notice of Deficiencies. The Plan of Correction must identify the actions that have been, or will be taken to comply with this

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Part and the timeframes for implementing the corrective actions.

- iv) The Provider must submit the Plan of Correction to the Certifying State Agency by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies.
 - v) The Certifying State Agency shall review the Plan of Correction and notify the Provider of the results of the review within 30 days after submission of the Plan of Correction. If a Provider submits a Plan of Correction that does not address the deficiencies noted during a review, the Certifying State Agency shall notify the Provider within 30 days after receipt of the Provider's Plan of Correction. The Provider shall submit a revised Plan of Correction that addresses the deficiencies within 10 days after the date it was notified of the unacceptable Plan of Correction. Pursuant to Section 132.47, the Certifying State Agency may suspend the Provider's certification if the Provider fails to submit an acceptable revised Plan of Correction within 10 days after the date of notification.
- C) Level 3 – Minimally Compliant: 50-74% Compliance
- i) Providers who score a Level 3 will not be considered to be in good standing with the Certifying State Agency.
 - ii) The Certifying State Agency shall report any deficiencies to the Provider during an exit conference. The Certifying State Agency shall issue a Notice of Deficiencies to the Provider within 30 days after the completion of the review.
 - iii) The Provider shall submit a written Plan of Correction to address each of the deficiencies included in the Notice of Deficiencies. The Plan of Correction must identify the actions that have been, or will be, taken to comply with this

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Part and the timeframes for implementing the corrective actions.

- iv) The Provider must submit the Plan of Correction to the Certifying State Agency by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies.
- v) The Certifying State Agency shall review the Plan of Correction and notify the Provider of the results of the review within 30 days after submission of the Plan of Correction. If a Provider submits a Plan of Correction that does not address the deficiencies noted during a review, the Certifying State Agency shall notify the Provider within 30 days after receipt of the Provider's Plan of Correction. The Provider shall submit a revised Plan of Correction that addresses the deficiencies within 10 days after the date it was notified of the unacceptable Plan of Correction. Pursuant to Section 132.47, the Certifying State Agency may suspend the Provider's certification if the Provider fails to submit an acceptable revised Plan of Correction within 10 days after the date of notification.
- vi) Within 90 days after the date that the Plan of Correction is approved, the Certifying State Agency shall conduct a Level 3 focused review to evaluate the Provider's implementation of the Plan of Correction. The Provider's level of compliance must reach the equivalent of at least Level 2 to demonstrate implementation of the Plan of Correction.
- vii) The Certifying State Agency shall report any remaining deficiencies to the Provider during an exit conference.
- viii) If the Provider fails to implement the Plan of Correction within 90 days from the date of the Plan of Correction acceptance, as evidenced by less than the equivalent of a Level 2, the Certifying State Agency may suspend the

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Provider's certification to provide services pursuant to this Part.

- D) Level 4 – Unsatisfactorily Compliant: Under 50% Compliance
- i) Providers who score a Level 4 will not be considered to be in good standing with the Certifying State Agency.
 - ii) The Certifying State Agency shall report any deficiencies to the Provider during an exit conference. The Certifying State Agency shall issue a Notice of Deficiencies to the Provider within 30 days after the completion of the review.
 - iii) The Provider shall submit a written Plan of Correction to address each of the deficiencies included in the Notice of Deficiencies. The Plan of Correction must identify the actions that have been, or will be, taken to comply with this Part and the timeframes for implementing the corrective actions.
 - iv) The Provider must submit the Plan of Correction to the Certifying State Agency by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies.
 - v) The Certifying State Agency shall review the Plan of Correction and notify the Provider of the results of the review within 30 days after the submission of the Plan of Correction. If a Provider submits a Plan of Correction that does not address the deficiencies noted during a review, the Certifying State Agency shall notify the Provider within 30 days after receipt of the Provider's Plan of Correction. The Provider shall submit a revised Plan of Correction that address the deficiencies within 10 days after the date it was notified of the unacceptable Plan of Correction. Pursuant to Section 132.47, the Certifying State Agency may suspend Provider's certification if the Provider fails to

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- submit an acceptable revised Plan of Correction within 10 days after the date of notification.
- vi) Within 60 days after the date that the Plan of Correction is approved, the Certifying State Agency shall conduct a Level 4 focused review to evaluate the Provider's implementation of the Plan of Correction. The Provider's level of compliance must reach the equivalent of a least Level 3 to demonstrate implementation of the Plan of Correction.
- vii) The Certifying State Agency shall report any remaining deficiencies to the Provider during an exit conference.
- viii) If the Provider fails to implement the Plan of Correction within the designated timeframe, as evidenced by achieving less than the equivalent of Level 3, the Certifying State Agency may suspend the Provider's certification to provide services pursuant to this Part.
- ix) Within 90 days after the date that the Plan of Correction is approved, the Certifying State Agency may conduct a Second Level 4 focused review to evaluate the Provider's implementation of the Plan of Correction. The Provider's level of compliance must reach the equivalent of at least Level 2 to demonstrate implementation of the Plan of Correction. If the Provider's level of compliance in the first Level 4 focused review reached the equivalent of a least at Level 2, the Second Level 4 focused review is not required.
- x) The Certifying State Agency shall report any remaining deficiencies to the Provider during an exit conference.
- xi) If the Provider fails to implement the Plan of Correction within 60 days from the date of the Plan of Correction acceptance, as evidenced by achieving less than the equivalent of Level 2, the Certifying State Agency may

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suspend the Provider's certification to provide Part 132 services.

- 2) Initial Certification Focus Review
For all Providers that scored a Level 2 through 4 in their initial certification review, within 12 months after the date that the Plan of Correction was approved, the Certifying State Agency shall conduct an initial certification focus review to evaluate the Provider's implementation of the Plan of Correction.
- A) The Certifying State Agency shall report any remaining deficiencies to the Provider during an exit conference. The Certifying State Agency shall issue an Initial Certification Focus Review Notice of Deficiencies to the Provider within 30 days after the completion of the review.
- B) The Provider shall submit a written Amended Plan of Correction to address each of the remaining deficiencies. The Amended Plan of Correction must identify the actions that have been, or will be, taken to comply with this Part and the timeframes for implementing the corrective actions.
- C) The Provider must submit the Amended Plan of Correction to the Certifying State Agency by the due date indicated on the Notice of Deficiencies, which will be approximately 30 days after the date of the Notice of Deficiencies.
- D) The Certifying State Agency shall review the Amended Plan of Correction and notify the Provider of the results of the review within 30 days after submission of the Plan of Correction.
- b) Three Year Recertification Review
The Certifying State Agency will conduct a full review of the Provider's compliance with all requirements of this Part on or around the expiration date of the current certification. At this review, the Certifying State Agency shall evaluate the Provider's level of compliance under subsection (a)(1).

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- 1) For all Providers that score a Level 2 through 4 in their three year recertification review, within 14 months after the date that the Recertification Review Plan of Correction was approved, the Certifying State Agency shall conduct a recertification focus review to evaluate the Provider's implementation of the Plan of Correction. The focus review and follow-up will be conducted pursuant to subsection (a)(2).
- 2) For all Providers that score Level 2 through 4 in their three year recertification review, a follow-up focus review may be done within 12 months after the date that the Recertification Focus Review Plan of Correction was approved to evaluate the Provider's implementation of the Plan of Correction. The focus review and follow-up will be conducted pursuant to subsection (a)(2).
- c) The Certifying State Agency, or its respective agents, shall be granted access to all Provider sites. All records shall be made available to the Certifying State Agency, HFS, or their respective agents, on request during any certification, recertification or other compliance review for Part 132 services. Access to records shall occur in accordance with the Confidentiality Act.

(Source: Added at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.33 Certification of New Sites of Services

- a) Providers that seek certification for a new site shall submit the following documents to the Certifying State Agency:
 - 1) A clearance letter from the Office of the State Fire Marshal or approved local fire authority, dated within the preceding 12 months, stating that the additional site complies with local and State fire safety ordinances and codes pursuant to Section 132.90(b)(1). For Providers certified by DHS, the clearance letter must come from the Office of the State Fire Marshal only.
 - 2) A signed statement from the Provider, dated within the preceding 12 months, attesting to compliance with requirements of physical accessibility standards pursuant to Section 132.90(a) and, when applicable, the Provider's plan for reasonable modifications of the site to

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meet the service needs of Clients unable to access the site due to physical inaccessibility.

- 3) A list of the Part 132 services that will be provided at the site.
- b) Providers that seek certification for additional Part 132 services pursuant to Sections 132.148, 132.150 and 132.165 shall submit a description of the additional services, including evidence of compliance with specific service definition in this Part, and the sites where the services will be delivered. The description shall state how the additional services will be provided within the Providers' program and shall include a listing of the LPHAs and QMHPs who will be responsible for directing the services. The Provider shall submit the documents for certification of additional services to the Certifying State Agency.
- c) Additional sites or services must be approved by the Certifying State Agency before the additional sites or services may be used or provided.
- d) Approved additional sites or services shall be indicated on a revised certificate. If additional sites are certified, the Provider shall enroll the sites in the Illinois medical assistance program. The addition of sites or service will not alter the expiration date of the certificate.
- e) The Certifying State Agency shall include all additional sites or services on the next on-site certification review.

(Source: Added at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.42 Post-Payment Review

The ~~Public Payer~~public payer may conduct post-payment reviews to determine billing amounts subject to recoupment as a result of non-compliance with this Part. ~~The Public Payer, HFS, or their respective agents shall be granted access to all Provider sites. All records shall be made available to the Public Payer, HFS, or their respective agents, on request during any post-payment review for payment of services delivered under this Part. Access to records shall occur in accordance with the Confidentiality Act and to determine amounts subject to recoupment.~~

- a) The ~~Public Payer~~public payer shall compare billed services to those listed on the Admission Note, Healthy Kids screen, MHA or ITP in effect at the time service

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was provided. The ~~Public Payer~~~~public payer~~ will determine that a billing will be unsubstantiated for any of the following:

- 1) Billings for services without a completed Admission Note, Healthy Kids screen, MHA or ITP being in effect, except for mental health assessment; ITP development, review and modification; crisis intervention; case management transition linkage and aftercare; or mental health case management pursuant to Section 132.165(a)(1);
 - 2) Billings for services that the ~~Provider~~~~provider~~ is not certified to provide;
 - 3) Billings for services not listed on the currently effective Admission Note, Healthy Kids screen, MHA or ITP being in effect, except for mental health assessment; ITP development, review and modification; crisis intervention; case management transition linkage and aftercare; or mental health case management pursuant to Section 132.165(a)(1); or
 - 4) Billings that do not comply with the requirements in this Part.
- b) The post-payment review must verify compliance with the requirements identified in subsection (a) ~~of this Section~~.
- c) The ~~Public Payer~~~~public payer~~ will report its findings to the ~~Provider~~~~provider~~ within 30 days after the review through a Notice of Unsubstantiated Billings that will identify the billings found to not be documented in compliance with this Part and the dollar amount associated with those bills. The Notice will include: services that were found not to be compliant as required in subsection (a), as well as the dollar amount associated with those services.
- 1) The reason for the Public Payer's findings;
 - 2) A statement of the Provider's right to request a hearing within 20 days after the date of receipt of the notice;
 - 3) A statement of the legal authority and jurisdiction under which the hearing is to be held; and
 - 4) The address where a request for hearing may be filed.

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- d) The ~~Provider~~provider will have 30 days after the date of the Notice of Unsubstantiated Billings to submit a plan to address the compliance problems identified during the post-payment review as required by the ~~Public Payer~~public payer.
- e)2) The ~~Public Payer~~Certifying State Agency shall verify the ~~Provider's~~provider's implementation of the plan.
- f)4) If it is determined that less than 50% of the billings reviewed comply with requirements identified in subsection (a), the ~~Public Payer~~public payer will also submit to the ~~Provider~~provider a Notice of Suspension from Billing along with the Notice of Unsubstantiated Billings, within 30 days after the post-payment review.
- 1) When a ~~Provider~~provider receives a Notice of Suspension from Billing, the ~~Provider~~provider will immediately stop submitting bills for Medicaid community mental health services under this Part funded by the Public Payer that notified them of the suspension.
 - 2) The ~~Provider~~provider will have 60 days to make corrections to its documentation processes to bring them into compliance with this Part.
 - 3) When the ~~Provider~~provider notifies the ~~Public Payer~~public payer and the ~~Certifying State Agency~~ in writing that it has made the necessary corrections, the ~~Public Payer~~Certifying State Agency will review those corrections for compliance with this Part within 14 days after receiving the notification.
 - 4) If compliant, the ~~Provider~~provider will be notified that the suspension from billing has been lifted and that the ~~Provider~~provider may resume billing.
 - 5) Once suspension from billing is lifted, the ~~Provider~~provider may submit bills that have the required documentation for services provided during the suspension.
 - 6) If corrections are not made within 60 days, the Certifying State Agency may suspend the Provider's~~shall revoke the provider's~~ certification.

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- ge) The Public Payer~~public payer~~ shall notify the State Medicaid Agency of the findings from all post-payment reviews.
- hf) The Public Payer will~~public payer may~~ recover funds based upon the findings of the post-payment review. The Public Payer~~public payer~~ may use the findings of the post-payment review to extrapolate the amount of funds to be recovered from the total bills from which the sample was drawn when the sample is statistically valid.
- ig) The Provider~~provider~~ may appeal the Public Payer's~~public payer's~~ intent to recover funds as specified in Section 132.44.
- jh) If the Public Payer~~public payer~~ finds evidence of suspected Medicaid fraud or abuse, the State agency shall refer such evidence to HFS, Office of Inspector General for further action.
- ki) Nothing in this Section shall preclude HFS, as the State Medicaid Agency, from conducting post-payment reviews of any bill that is fully or partially reimbursed with federal funds.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.44 Appeal of Post-Payment Review Findings

- a) ~~If the State agency determines that the provider is not in compliance with the requirements of this Part pursuant to a post-payment review conducted in accordance with Section 132.42, the State agency shall notify the provider in writing of its findings. The notice shall include:~~
- 1) ~~The reason for the State agency's findings;~~
 - 2) ~~A statement of the provider's right to request a hearing within 20 days after the date of receipt of the written notice;~~
 - 3) ~~A statement of the legal authority and jurisdiction under which the hearing is to be held; and~~

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- 4) ~~The address where a request for hearing may be filed.~~
- ab) If a ~~Provider~~~~provider~~ chooses to appeal the State agency's findings, the ~~Provider~~~~provider~~ shall submit a written request for a hearing to the State agency within 20 days after the date of receipt of the written Notice of Unsubstantiated Billings~~notice~~. The appeal shall specify the grounds for the appeal.
- be) The sole issue at the hearing shall be whether the ~~Provider~~~~provider~~ is in compliance with requirements set forth in this Part.
- cd) The request for hearing shall be filed with, and received by, the State agency within 20 days after the date of the receipt of the written notice to the ~~Provider~~~~provider~~.
- de) Hearing Process~~process~~
- 1) HFS's hearing rules for medical vendor hearings at 89 Ill. Adm. Code 104.200 shall apply, except that the following Sections do not apply to these hearings: 104.204, 104.206, 104.208, 104.210, 104.216, 104.217, 104.221, 104.260, 104.272, 104.273 and 104.274.
 - 2) The State agency shall, within 5 days after receiving the appeal, send a copy of the appeal to the Illinois Department of Healthcare and Family Services Vendor Hearings Section, 401 South Clinton, 6th Floor, Chicago, Illinois 60607.
 - 3) The appellant shall direct all subsequent communications relevant to the hearing to the HFS Vendor Hearings Section.
 - 4) An administrative law judge appointed by HFS shall conduct the hearing.
 - 5) A recommended decision shall be submitted to the Director of Healthcare and Family Services and copies mailed to the parties, in accordance with the provisions of 89 Ill. Adm. Code 104.290. A copy shall also be mailed to the State agency that referred the matter to HFS.
- ef) Final Administrative Decision~~administrative decision~~

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The Director of Healthcare and Family Services shall issue a final administrative decision in accordance with the provisions of 89 Ill. Adm. Code 104.295.

- ~~fg)~~ Judicial ~~Review~~review
The final administrative decision shall be subject to judicial review exclusively as provided in the Administrative Review Law [735 ILCS 5/Art. III].
- ~~gh)~~ A ~~Provider~~provider shall be liable for reimbursement of bills submitted from the date of the final administrative decision pursuant to this Section if such decision results in an adverse finding for the ~~Provider~~provider.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.45 Compliance with Certification Requirements (Repealed)

- ~~a)~~ ~~Medicaid community mental health service providers shall be recognized according to levels of compliance with standards as set forth in this Part. Providers with findings of Level 1 and 2 will be considered to be in good standing with the State agency. The levels of compliance are:~~
- ~~1) Level 1—Compliant: No written Plan of Correction will be required of the provider (90-100% compliance).~~
 - ~~2) Level 2—Substantial compliance: A Notice of Deficiencies is issued. The provider shall submit a written Plan of Correction to address the identified deficiencies. Within 12 months after the date that a Plan of Correction is approved, the Certifying State Agency shall conduct a review to evaluate the provider's implementation of the Plan of Correction. If the provider fails to submit and implement a Plan of Correction within the designated time frame, the Certifying State Agency may revoke the provider's certification to provide services pursuant to this Part (75-89% compliance).~~
 - ~~3) Level 3—Minimal compliance: A Notice of Deficiencies is issued. The provider shall submit a written Plan of Correction to address the identified deficiencies. After 90 days from the date that a Plan of Correction is approved, the Certifying State Agency shall conduct a review to evaluate the provider's implementation of the Plan of Correction. The provider's~~

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~~level of compliance must reach at least Level 2 to demonstrate implementation of the Plan of Correction. If the provider fails to submit and implement a Plan of Correction within the designated time frame, the Certifying State Agency may revoke the provider's certification to provide services pursuant to this Part (50-74% compliance).~~

- 4) ~~Level 4—Unsatisfactory compliance: A Notice of Deficiencies is issued. The provider shall submit a written Plan of Correction to address the cited deficiencies. After 60 days from the date that a Plan of Correction is approved, the Certifying State Agency shall conduct a review to evaluate the provider's implementation of the Plan of Correction. The provider's level of compliance must reach at least Level 3 to demonstrate implementation of the Plan of Correction. After 90 days from the date that the Plan of Correction was approved, the provider's level of compliance must reach at least Level 2 to demonstrate implementation of the Plan of Correction. If the provider fails to submit and implement a Plan of Correction within the designated time frames, the Certifying State Agency may revoke the provider's certification to provide services pursuant to this Part (under 50% compliance).~~

- b) ~~When a written Plan of Correction is required, the provider shall submit the Plan of Correction within 30 days after receipt of the Notice of Deficiencies.~~

(Source: Repealed at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.47 Suspension of Certification

The Certifying State Agency may suspend certification during a certification period for any~~either~~ of the following reasons:

- a) A Provider~~provider~~ discontinues delivery of all Medicaid community mental health services for which the Provider~~provider~~ has been certified; ~~or~~
- b) A Provider~~provider~~ has less than 50% of its reviewed bills substantiated in a post-payment review and has not made required corrections within 60~~with 30~~ days pursuant to Section 132.42(f)(2);-
- c) A Provider fails to submit a Plan of Correction; or

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- d) A Provider fails to implement a Plan of Correction.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.48 Reinstatement Following Suspension of Certification

Certification will be reinstated from suspension by the Certifying State Agency when:

- a) A ~~Provider~~provider begins delivery of Medicaid community mental health services as defined under ~~Sections 132.148, 132.150 and 132.165~~Section 132.145(a) prior to one calendar year from the date of suspension under Section 132.47(a); ~~or~~
- b) An on-site review of the ~~Provider~~provider shows that corrections have been made to its documentation process so that it is in compliance with this Part prior to the end of one calendar year from the date of suspension under Section 132.47(b).
- c) A Provider submits a Plan of Correction and demonstrates implementation of the Plan of Correction prior to the end of one calendar year from the date of suspension under Section 132.47(c) and (d).

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.50 Revocation of Certification

The Certifying State Agency ~~may~~shall issue a written notice revoking certification during a certification period for any of the following:

- a) Provider ~~meets~~meeting any of the grounds for termination set forth in 89 Ill. Adm. Code 140.16; ~~or~~
- b) Provider being convicted of defrauding the medical assistance program under Article VIII A of the Illinois Public Aid Code [305 ILCS 5/Art. VIII A]; ~~or~~
- c) Provider's certificate is suspended longer than one calendar year; or;
- d) Provider shows a consistent failure to correct deficiencies and maintain those

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corrections by scoring 74% or less during two consecutive recertification reviews or having less than 50% of its reviewed bills substantiated in two consecutive post-payment reviews.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.55 Appeal of Certification Decisions

- a) An applicant or ~~Provider~~provider may appeal the following to the Certifying State Agency:
 - 1) Refusal to issue certification;
 - 2) Refusal to issue recertification;
 - 3) Suspension of certification; or
 - 4) Revocation of certification.
- b) Certification ~~Appeal Criteria~~appeal criteria and ~~Process~~process
 - 1) If the Certifying State Agency determines that certification or recertification ~~shall~~should not be issued, that certification ~~shall~~should be suspended, or that certification ~~shall~~should be revoked, the Certifying State Agency shall send written notice to the applicant or the ~~Provider~~provider within 30 days after the determination. The notice shall contain the specific requirements with which the applicant or ~~Provider~~provider has not complied, the Certifying State Agency's proposed action, and the applicant or ~~Provider~~provider rights as follows:
 - A) If the applicant or ~~Provider~~provider chooses to appeal the Certifying State Agency's decision, the applicant or ~~Provider~~provider shall submit a written request for a hearing to the Certifying State Agency within 20 days after the dated receipt of the notice.
 - B) If an appeal is initiated by a ~~Provider~~provider, services shall be continued pending a final administrative decision.

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- C) The request for a hearing shall be addressed to the appropriate Certifying State Agency as follows:

Illinois Department of Human Services
Bureau of Administrative Hearings
100 South Grand Avenue East, 3rd Floor
Springfield IL 62762-0001

or

Illinois Department of Children and Family Services
Office of Medicaid Certification
406 East Monroe
Springfield IL 62701-1498

- 2) If the applicant or ~~Provider~~provider does not submit a request for a hearing, as provided in ~~this Section~~this Part, or if, after conducting the hearing, the Certifying State Agency determines that the certification or recertification ~~shall~~should not be issued or that the certification ~~shall~~should be revoked, the Certifying State Agency shall issue an order to that effect. If the order is to revoke the certification, it shall specify that the order takes effect upon receipt by the ~~Provider~~provider and that the ~~Provider~~provider shall not provide Medicaid community mental health services during the pendency of any proceeding for judicial review of the Certifying State Agency's decision, except by court order.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

SUBPART B: PROVIDER ADMINISTRATIVE REQUIREMENTS

Section 132.80 Fiscal Requirements

- a) ~~Providers shall have a formal accrual accounting system in accordance with any generally accepted accounting principles (GAAP).~~
- b) ~~The provider shall submit to the Certifying State Agency within 180 days after the end of the State fiscal year the State of Illinois Consolidated Financial Report,~~

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~~unless the State agency extends the time frame for a provider.~~

- a)e) The ~~Provider~~provider shall comply with the requirements governing audits, false reporting and other fraudulent activities pursuant to 89 Ill. Adm. Code 140.30 and 140.35 for services provided to Medicaid-eligible ~~Client~~clients.
- d) ~~Billings for services rendered under this Part shall be submitted only by the provider that directly provided the service and only to the public payer with which the provider has contracted for the service.~~
- be) The ~~Provider~~provider shall determine if there are any third party payers liable for treatment costs incurred by a ~~Client~~client and shall follow procedures for seeking payment from these parties and for calculating subsequent Medicaid charges as outlined in 89 Ill. Adm. Code 140. A third-party payer is any entity, other than the ~~Client~~client or ~~Public Payer~~public payer, with an obligation to the ~~Client~~client to pay for ~~services defined in this Part~~ 132 services.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.90 Provider Sites

For the purpose of this Part, ~~Provider~~provider sites are discrete locations, other than a licensed foster family home, that are owned or leased by a ~~Provider~~provider for the purpose of providing Medicaid community mental health services.

- a) The ~~Provider~~provider shall use sites deemed accessible in accordance with the Americans With Disabilities Act of 1990, as amended, and the Illinois Accessibility Code and the ADA Accessibility Guidelines, whichever is more stringent. ~~The Certifying State Agency may require specific accommodations to meet the needs of clients served at a particular site as determined on a case-by-case basis.~~ Providers must maintain a written policy for reasonable modifications for the provision of services to ~~Client~~clients unable to access the ~~Provider's~~provider's sites due to physical inaccessibility.
- b) Provider sites shall be in compliance with approved State and local ordinances and codes relating to fire, building and sanitation, and health and safety requirements as follows:

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- 1) Fire safety in accordance with rules of the Office of the State Fire Marshal at 41 Ill. Adm. Code 100.
 - 2) Building requirements shall be in compliance with the uniform or national building code adopted by the local or county ordinance. ~~Documentation may include a written statement from an electrician or licensed architect stating that the site is in compliance with applicable electrical codes and a written statement from a licensed plumber or licensed architect stating that the site is in compliance with applicable plumbing codes.~~
- c) To ensure the sanitation, health and safety of the sites, the Provider~~provider~~ shall:
- 1) Develop and maintain a written external and internal emergency disaster plan, including a fire evacuation plan. External disasters include such occurrences as tornados, earthquakes and floods. Internal disasters include such occurrences as fire and heating and cooling systems failures.
 - 2) Designate space, equipment, and furnishings for the provision of services which shall be conducive to privacy, comfort and safety. This includes such aspects as child size furniture in children's programs, rooms sufficiently large to accommodate groups or families, and doors that close to afford privacy.
- d) If a Provider~~provider~~ offering only non-residential services is accredited and is in compliance with this Section at the time of recertification, on-site inspections may not be required for recertification purposes. Sites offering residential services are subject to an on-site inspection for recertification. All new sites shall be required to undergo on-site inspections.
- e) If a certified site is licensed by DCFS as a child care institution or group home, an on-site inspection of that site may not be required for recertification purposes. The site must be in good standing with DCFS and must be in compliance with this Section at the time of recertification. All new sites shall be required to undergo on-site inspection.
- f) The Certifying State Agency shall not review the requirements in this Section if the Provider~~provider~~ delivers Medicaid services exclusively in locations other than Provider~~provider~~ sites.

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(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.91 Accreditation

- a) The Certifying State Agency shall grant deemed status to ~~Providers~~providers having a contract with the State agency and demonstrating current accreditation status under any of the standards of the following accrediting organizations:
- 1) 2012 Hospital Accreditation Standards (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);
 - 2) 2012 Standards for Behavioral Health Care (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);
 - 3) 2012 Comprehensive Accreditation Manual for Health Care Networks (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);
 - 4) Council on Accreditation Standards, Eighth Edition (Council on Accreditation of Services for Families and Children (COA), 120 Wall Street, 11th Floor, New York, New York 10005, 2012);
 - 5) Quality Outcomes 2012 (The Council on Quality and Leadership, 100 West Road, Suite 406, Towson, Maryland 21204, 2012);
 - 6) Standards Manual and Interpretive Guidelines for Behavioral Health (Commission on Accreditation of Rehabilitation Facilities (CARF), 4891 East Grant Road, Tucson, Arizona 85711, 2012); or
 - 7) Healthcare Facilities Accreditation Program (HFAP), (2008 Accreditation Requirements for Mental Health Centers, 142 E. Ontario Street, Chicago IL 60611).
- b) "Deemed status" means that if a ~~Provider~~provider has been accredited by any of

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the accrediting organizations identified in subsections (a)(1) through (a)(7) ~~of this Section~~, the Certifying State Agency shall deem the ~~Provider~~~~provider~~ to be in compliance with the following Sections of this Part:

- 1) Section 132.65(a), ~~(b), (c), (d) and (e)~~;
 - 2) ~~Section 132.65(e)~~
 - 3) ~~Section 132.65(e)(1)~~;
 - 24) Section 132.70(a), ~~and (b) and (e)~~;
 - 3) ~~Section 132.80(a)~~;
 - 45) Section 132.85(a), (b), (c), (d) and (e);
 - 5) ~~Section 132.90(a), (b)(2), (c), (d), (e) and (f)~~;
 - 6) ~~Section 132.95(b), (d), (e), (f), (g), (h), (i) and (j)~~;
 - 76) Section 132.100(b), (c), (d), (f), (g), (h), (j), (k) and (l); ~~and~~
 - 7) ~~Section 132.100(e)~~; and
 - 8) Section ~~132.145(c)~~.~~132.100(f)~~.
- c) Demonstration of current accreditation status shall be achieved by submission of a certificate of accreditation and the most recent accreditation report by the ~~Provider~~~~provider~~ to the Certifying State Agency.
- d) If the ~~Provider's~~~~provider's~~ accreditation is suspended, lost or discontinued, the ~~Provider~~~~provider~~ shall notify the Certifying State Agency of that change within 30 days after the effective date of the change.
- e) Deemed status may be nullified by a finding by the Certifying State Agency that the ~~Provider~~~~provider~~ is non-compliant with one or more of the Sections identified in subsection (b).

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- f) Granting of deemed status is subject to annual review of national accreditation standards and revision of this Part pursuant to the Illinois Administrative Procedure Act [5 ILCS 100].

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

Section 132.100 Clinical Records

The Client's~~client's~~ clinical record shall contain, but is not limited to the following:

- a) Identifying information, including Client's~~client's~~ name, Medicaid recipient identification number, address and telephone number, gender, date of birth, primary language, method of communication, and documentation of how anything other than verbal English communication needs were accommodated, name and phone number of emergency contact, date of initial contact and initiation of mental health services, third party insurance coverage, marital status, and source of referral;
- b) Documentation of consent for or refusal of mental health services;
- c) Assessment and reassessment reports;
- d) A single consolidated ITP within a Provider~~provider~~ organization. The ITP must be current;
- e) Admission Note or Healthy Kids screen, if applicable;
- f) Documentation concerning the prescription and administration of psychotropic medication as specified in Section 132.150(c)(1);
- g) Documentation of missed appointments;
- h) Documentation of Client~~client~~ referral or transfer during any active service period to or from the Provider's~~provider's~~ programs or to or from other providers;
- i) Documentation to support services provided for which reimbursement is claimed shall be in the format specified by the Public Payer~~public payer~~, shall be legible, shall support the amount of time claimed, and shall include, but not be limited to,

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the following elements:

- 1) The specific service, including whether the service was rendered in a group, individual or family setting and a note in the periodic report indicating the specific Part 132 mental health services billed by name or code;
- 2) The date the service was provided;
- 3) The start time and duration for each service;
- 4) The original signature, name and credential of the staff providing the service;
- 5) The site or, if off-site, the specific off-site location where services were rendered; and
- 6) Written documentation of each service provided ~~describing the interaction that occurred during service delivery, including the client's response to the interventions and progress toward attainment of the goals in the ITP as described by service~~ in Section 132.148, 132.150 or 132.165;
- j) ITP reviews describing the Client's/Client's overall progress;
- k) A written record of the Client's/Client's major accidents or incidents that ~~occurred~~ occur at the site ~~with regard to a specific client~~, whether self-reported or observed, and resulting in an adverse change in the Client's/Client's physical or mental functioning; and
- l) Discharge summary documenting the outcome of treatment and, as necessary, the linkages for continued services.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)

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- 1) Heading of the Part: Improper Claims Practice
- 2) Code Citation: 50 Ill. Adm. Code 919
- 3)

<u>Section Numbers:</u>	<u>Adopted Action:</u>
919.40	Amendment
919.EXHIBIT A	Amendment
- 4) Statutory Authority: Implementing Sections 154.5 and 154.6 of the Illinois Insurance Code [215 ILCS 5/154.5 and 154.6] and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401], Section 10 of the Voluntary Health Services Plans Act [215 ILCS 165/10], Section 25 of the Dental Service Plan Act [215 ILCS 110/25] and Section 5-3 of the Health Maintenance Organization Act [215 ILCS 125/5-3]
- 5) Effective Date of Rule: July 2, 2014
- 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 rule, 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*: 38 Ill. Reg. 4999; February 21, 2014
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: Corrected typographical errors in 919.EXHIBIT A(2) item 3, 1st and 2nd lines and 919.EXHIBIT A(9) item 1, 1st line.
- 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 any emergency rule 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 rule was amended to update Department contact information.
- 16) Information and questions regarding this adopted rule shall be directed to:

Robert Rapp, Assistant Deputy Director
Property and Casualty Division
Department of Insurance
320 West Washington Street
Springfield IL 62767-0001

217/785-1680

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

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER I: PROVISIONS APPLICABLE TO ALL COMPANIESPART 919
IMPROPER CLAIMS PRACTICE

Section	
919.10	Authority
919.20	Scope and Purpose
919.30	Examinations
919.40	Definitions/Explanations
919.50	Required Practices for all Insurance Companies
919.60	Improper Practices or Procedures for all Insurance Companies
919.70	Required Claims Practices – Life, Accident and Health Companies
919.80	Required Claim Practices – Private Passenger Automobile – Property and Casualty Companies
919.90	Improper Practices or Procedures – Property and Casualty Companies
919.100	Severability Provision
919.EXHIBIT A	Total Loss Automobile Claims

AUTHORITY: Implementing Sections 154.5 and 154.6 of the Illinois Insurance Code [215 ILCS 5/154.5 and 154.6] and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401], Section 10 of the Voluntary Health Services Plans Act [215 ILCS 165/10], Section 25 of the Dental Service Plan Act [215 ILCS 110/25] and Section 5-3 of the Health Maintenance Organization Act [215 ILCS 125/5-3].

SOURCE: Filed June 17, 1974, effective July 1, 1974; amended at 2 Ill. Reg. 22, p. 77, effective May 22, 1978; new rules adopted at 3 Ill. Reg. 31, p. 93, effective August 4, 1979; old rules repealed 3 Ill. Reg. 32, p. 42, effective August 6, 1979; emergency amendment and codified at 7 Ill. Reg. 2755, effective February 28, 1983, for a maximum of 150 days; amended and codified at 7 Ill. Reg. 11489, effective October 1, 1983; amended at 10 Ill. Reg. 5125, effective March 17, 1986; amended at 13 Ill. Reg. 1204, effective January 11, 1989; amended at 26 Ill. Reg. 11915, effective July 22, 2002; amended at 27 Ill. Reg. 19287, effective December 10, 2003; amended at 28 Ill. Reg. 9253, effective July 1, 2004; amended at 38 Ill. Reg. 15600, effective July 2, 2014.

Section 919.40 Definitions/Explanations

DEPARTMENT OF INSURANCE

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"Code" means the Illinois Insurance Code [215 ILCS 5].

"Company" ~~means~~ ~~refers to~~ any licensee of the Department of Insurance, including health maintenance organizations.

"Days" for the purpose of this Part, means calendar days.

"Department" means the Illinois Department of Insurance.

"Director" means the Director of the Illinois Department of Insurance.

"Documentation" ~~means~~ ~~shall mean~~ all pertinent communications, transactions, notes and work papers. All such communications, transactions, notes and work papers shall be properly dated and compiled in sufficient detail in order to allow for the reconstruction of all pertinent events relative to each claim file. Documentation shall include but not be limited to bills, explanations of benefits and worksheets.

"First Party" means any individual, corporation, association, partnership, or other legal entity asserting a contractual right to payment under an insurance policy or insurance contract arising out of the contingency or loss covered by ~~the~~ ~~such~~ policy or contract.

"Insured" ~~means~~ ~~shall mean~~, for the purposes of life, accident and health insurance or other health care or service plans, the party named on a contract as the individual, corporation or association with legal rights to the benefits provided by ~~the~~ ~~such~~ contract. This includes certificate holders or subscribers to a group contract and enrollees of a health maintenance organization, any other type of health care or service plans, or third party administrator. For purposes of property and casualty insurance, the party named on the contract is the insured.

"Non-Original Manufacturer" means any manufacturer other than the manufacturer of the original part.

"Notice of Availability of the Department of Insurance", as required by this Part, shall be no less informative than the following:

Part 919 of the Rules of the Illinois Department of Insurance requires that

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our company advise you that, if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor~~100 W. Randolph Street, Suite 15-100~~, Chicago, Illinois ~~6060360601~~ and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

"Notification of Loss" ~~means shall mean~~ communication, as required by the policy or that is otherwise acceptable by the insurer, from a claimant or insured to the insurer ~~that~~which identifies the claimant or insured and indicates that a loss has occurred or is about to occur.

"Pertinent Communication", as used in Section 154.6(b) of the Code ~~[215 ILCS 5/154.6(b)]~~, ~~means shall include~~ all correspondence, regardless of source or type, that is materially related to the handling of the claim.

"Policy", for the purpose of this Part, ~~means shall mean~~ a policy, certificate or contract issued to Illinois residents, including a certificate of enrollment into a health maintenance organization or any other type of health care or service plan.

"Private Passenger Automobile" ~~means a vehicle refers to vehicles~~ insured under a policy of automobile insurance as defined in Section 143.13 of the Code ~~[215 ILCS 5/143.13]~~.

"Prompt Investigation", as used in Section 154.6(c) of the Code ~~[215 ILCS 5/154.6(c)]~~, ~~means shall apply to~~ all activities of the company related directly or indirectly to the determination of liability based on claims under the coverage afforded by the policy and shall be evidenced by a bonafide effort to communicate with all insureds and claimants ~~when~~where liability is reasonably clear within 21 working days after a notification of loss. Evidence of ~~such~~ bonafide effort to communicate with insureds and claimants shall be maintained in the company's claim files.

"Reasonable Promptness", as used in Section 154.6(b) of the Code ~~[215 ILCS 5/154.6(b)]~~, ~~means shall mean~~ a maximum of 15 working days from receipt of communication from a claimant or insured.

"Replacement Crash Parts", for purposes of this Part, means sheet metal or synthetic parts, e.g., plastic, fiberglass, etc., that constitute the exterior of a motor

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vehicle, including inner and outer panels.

"Representative" ~~means shall include~~ any person expressly authorized to act on behalf of the insurer and any employee of the insurer who acts or appears to act on behalf of the insurer in matters relating to claims, including but not limited to independent contractors while performing claim services at the direction of the company.

"Settlement of Claims", as used in Section 154.6(c) of the Code ~~[215 ILCS 5/154.6(e)]~~, shall pertain to all activities of the company or its representatives, relating directly or indirectly to the determination of the extent of liabilities due or potentially due under coverages afforded by the policy. Evidence of ~~thosesueh~~ activities ~~shall~~ be maintained in the company's claim files.

"Third Party" refers to any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, partnership, or other legal entity insured under a policy.

(Source: Amended at 38 Ill. Reg. 15600, effective July 2, 2014)

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Section 919.EXHIBIT A Total Loss Automobile Claims

1) Total Loss Claims

When you are involved in an automobile accident, one of the first things you may have to do is file a claim for damages to your vehicle. If your car is a total loss, this procedure can sometimes be confusing.

Your automobile insurance policy requires both you and your insurance company to follow certain steps after a loss occurs. This publication summarizes those requirements and outlines your rights.

The Illinois Department of Insurance has established regulations to protect you when you file an insurance claim. It is also important that you read your policy carefully so that you clearly understand your responsibilities.

If you still have questions, you can contact our Consumer Services Section [by phone at \(866\) 445-5364](tel:8664455364) or at one of the following locations:

320 West Washington Street
Springfield, Illinois 62767
~~(217) 782-7446~~

OR

~~122 S. Michigan Ave., 19th Floor~~
~~100 West Randolph Street, Suite 15-100~~
Chicago, Illinois ~~6060360601~~
~~(312) 917-2427~~

2) Your Duties

1. You must immediately report all losses directly to your insurance producer or company.
2. If you suspect theft or vandalism, you must also report it immediately to the police. If you fail to do so, your company may deny your claim.

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3. You must protect your automobile from ~~further~~~~father~~ damage. For example, if you fail to cover a broken windshield and the ~~upholstery~~~~upholstry~~ is damaged by rain, your company can refuse to repair the seat.
4. Most insurance policies require that, within 91 days after the loss, you must submit a sworn proof of loss. A sworn proof of loss usually states the date of loss, how it happened, and for what purpose the automobile was being used. If you fail to submit a proof of loss your company may deny your claim.
5. You must cooperate with the insurance company, submit to examination under oath, if so requested, and show them the damaged property. If you fail to cooperate your company may deny your claim.
6. You should review the Conditions section of your policy for other possible requirements.

3) Your Insurance Company's Duties

When you file an automobile insurance claim, your insurance company has three options:

- 1) Replace the damaged or stolen property;
- 2) Repair the damaged property; or
- 3) Pay for the loss in cash.

Insurance Department regulations require the company to follow certain standards for each option.

4) Replacement

If the insurance company elects to replace your vehicle, the replacement must be a specific make and model comparable to your totalled vehicle, and it must be available in as good or better overall condition than your totalled vehicle.

Replacement vehicles must be purchased through licensed dealers. Vehicles that are no more than three years old must be warranted.

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If you reject a replacement vehicle, the insurance company must pay only the amount it would have otherwise paid for the replacement vehicle including applicable taxes, transfer and title fees. The company must offer you the replacement vehicle and you must reject the offer.

If you desire a replacement vehicle of similar value, this replacement method is also permitted.

5) Cash Settlement

If the insurance company elects to make a cash settlement for your totalled vehicle, they must first determine its retail value. Companies normally use guide books or computerized data marketed by various sources.

If your vehicle is not listed in one of these sources, the company can use written dealer quotes. Ordinarily, however, newspaper advertisements are not acceptable sources of market value.

6) Payment of Sales Tax

If within 30 days of a cash settlement, you can prove that you have purchased another vehicle, the company must pay the applicable sales tax, transfer and title fees in an amount equivalent to the value of the total loss vehicle. If you purchase a vehicle with a market value less than the amount previously settled upon, the company must pay you only the amount of sales tax that you actually incurred and include transfer and title fees.

Your insurance company must give you written notice of this procedure.

7) Betterment Deductions

The insurance company is allowed to make deductions from the retail value if your automobile has old, unrepaired collision damages. There is no limit to the amount of the deduction.

The insurance company can also make deductions for wear and tear, missing parts and rust, but the maximum deduction may not exceed \$500.00.

All deductions must be itemized and specified as to dollar amount.

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8) Retaining Your Totalled Vehicle

In an effort to minimize automobile "chop shop" crime, the Illinois Vehicle Code does not permit you the right to retain the salvage once your automobile has been deemed a total loss by your insurance company. The insurance company must take possession of the vehicle, if the vehicle is eight model years or newer.

9) Right of Recourse

If you cannot locate a replacement vehicle within 30 days of receiving a cash settlement, you may have some additional rights under your insurance contract.

If you cannot purchase a substantially similar vehicle for the market value determined by the company, but you have located a substantially similar vehicle that costs more, the following ~~procedures~~~~procedures(s)~~ shall apply.

- 1) The company shall either pay ~~you~~~~your~~ the difference between the original settlement and the amount of the substantially similar vehicle which you have located or attempt to purchase this vehicle for you; or
- 2) The company shall locate a comparable vehicle for you at the market value determined by the company at the time of settlement; or
- 3) The company shall conclude the loss settlement as provided under the appraisal section of the insurance policy.

Your insurance company must give you written notice of this procedure once your vehicle has been determined a total loss.

This chart should assist you in determining the retail value of your automobile.

Value

Make of Automobile
Model
Engine Size

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Type Transmission
(Auto/Standard)
Power Steering
Power Brakes
Power Windows
Air Conditioner
Vinyl Roof
Cruise Control
Tilt Wheel/Telescope Wheel
Power Locks
Power Seats
AM/FM Radio
Stereo/Tape
Rear Defog
Mileage: Low/High
Subtotal
Minus Deductible

Total

The above figure represents an average automobile. Your automobile may be worth more or less than the above figure because of options on the automobile which are not listed in a guide book or because of the excessive wear and tear or old unrepaired damage to the automobile.

(Source: Amended at 38 Ill. Reg. 15600, effective July 2, 2014)

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- 1) Heading of the Part: Assigned Risk Procedures
- 2) Code Citation: 50 Ill. Adm. Code 2904
- 3)

<u>Section Numbers</u> :	<u>Adopted Action</u> :
2904.10	Amendment
2904.20	Amendment
2904.30	Amendment
2904.40	Amendment
2904.50	Amendment
2904.60	Amendment
2904.70	Amendment
2904.80	Repealed
2904.90	Amendment
2904.100	Amendment
2904.110	Amendment
2904.130	Amendment
2904.140	Amendment
2904.160	Amendment
2904.170	Amendment
2904.190	Amendment
2904.220	Amendment
2904.230	Amendment
- 4) Statutory Authority: Implementing Sections 454 and 468 of the Illinois Insurance Code [215 ILCS 5/454 and 468] and authorized by Sections 401 and 466 of the Illinois Insurance Code [215 ILCS 5/401 and 466]
- 5) Effective Date of Rule: July 2, 2014
- 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 rule, 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*: 38 Ill. Reg. 184; January 3, 2014

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10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version:

Table of Contents, 2904.80, deleted "Administrator", reinstated "Bureau", and at the end added "Repealed)"; 2904.110, changed "of" to "after".

2904.30, first line – add "Workers'" before "Occupational"; 6th line, change "this Act" to "those Acts".

2904.40, definition of "Act", 1st line – after "Compensation" added "Act [820 ILCS 305]"; 2nd line, strike "Insurance", add "Act [820 ILCS 310]" and strike "Act".

2904.40, definition of "Administrator", 1st line - change "one" to "a qualified entity"; 3rd line add "Plan and" before "appropriate"; 3rd line, after "statutes/regulation" add ". At a minimum, a qualified entity holds a valid Illinois license that enables it to develop and file its Plan" and change "the filed" to "associated rates, rating plans, rules, forms and".

2904.40, definition of "Assigned Carrier", 3rd line -add "eligible" before "employer".

2904.40, after definition of "Assigned Carrier - add ""Plan" means the Illinois Workers' Compensation Assigned Risk Plan as filed by the Administrator and approved by the Director."

2904.40, definition of producer – after "under" add "Section 500 of the Illinois Insurance Code".

2904.50, 4th line – change "Section 9 of the Act" to "Sections 401 and 468 of the Illinois Insurance Code" [215 ILCS 5/401 and 468]".

2904.60(a), 2nd line - after "two" added "nonaffiliated"; after "insurance carriers" added "that are licensed to write and are actively writing workers' compensation insurance within the State"; 6th line, after "Coverage" added "at the time of application".

2904.60(b), 2nd line - deleted "in duplicate"; 4th and 5th lines, deleted "will designate an insurance carrier" and "that"; 10th and 11th lines, added "by the Administrator" after

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"will be bound"; changed "a plan assigned carrier" to "an Assigned Carrier"; changed "plan" to "Plan".

2904.60(c), 1st-3rd lines – changed "Upon receipt of notice of premium, the" to "The"; changed "shall forward the assigned carrier, at the carrier's address indicated in the assignment letter," to "must submit the required deposit premium or pay the annual estimated premium. For applications submitted by mail, payments must be in the form of"; 6th – 7th lines, changed "assigned carrier" to "Administrator" added "required deposit premium or the" after "for either the"; 7th lines, deleted "or a deposit of at least 25% of the estimated annual premium"; 8th line, changed "deposited" to "deposit"; added "and the Plan" after "Section 2904.100"; 11th line, changed "assigned carrier" to "Administrator"; 17th line, added space between "12:01" and "a.m."; 19th line, added ", as determined by the Administrator" after "received".

2904.70(a), 2nd line – added "nonaffiliated" after "two"; added "licensed and actively writing workers' compensation insurance within the state" after "insurance carriers"; 3rd line, capitalized "state"; 6th line, added "at the time of application" after "Coverage".

2904.70(b), 3rd line – changed "provide a quotation for" to "determine"; 4th line, changed "After" to "A completed and signed application must be received along with"; 5th -7th lines, deleted all text; 8th line, deleted "the estimated annual premium or if installment payments are requested,"; added "and the Plan" after "2904.100".

2904.70(c), 1st – 2nd lines – added "receipt of a completed" after "upon"; changed "for the binding of immediate coverage" to "and required deposit premium"; 2nd-6th lines, added "in accordance with Section 2904.60(b)." and deleted all text from "effective" to the end of the sentence; 6th line, changed "notify" to "provide to"; 7th and 8th lines, changed "in writing as to the effective date that coverage was bound" to "the complete binder package electronically the day after binding."; 9th-10th lines, change "mail" to "provide" and "agent or broker a" to "producer an electronic or hard copy"; 10th line, changed "ten" to "10"; 12th line, change "of the assignment" to "from the date of assignment of coverage from the Administrator and assigned carrier's receipt of required information"; 13th line, added "to the assigned carrier" after "remit"; 14th line, changed "payment" to "premium payments"; 17th line, changed "mailed" to "provided to the employer and producer"; 17th to 18th lines, changed "of mailing, on a recognized U.S. Postal Service Form, of" to "that"; added "was provided to the employer and producer" after "premium"; 14th line, changed "where" to "when"; 23rd line, deleted "of mailing of"; 24th line, added "was provided" after "premium".

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2904.70(d), 1st line – added "deposit" before "premium"; 5th line, changed "email" to "electronic communication"; 7th line, changed "application and check to the agent or producer" to "appropriate premium funds provided, if any, to the original payor"; added "to the producer" after "rejection".

2904.80 header – changed "Administrator" back to "Bureau" and then added "Repealed" and deleted all text in the Section; in source note, changed "Amended" to "Repealed".

2904.90 -- deleted all text in (a) and renumbered paragraphs (b), (c) and (d) to (a), (b) and (c)

2904.100, 1st line – changed "Minimum premium policies" to "Policies with an estimated premium of \$1,000 or less"; after "full" added "Payment of the estimated annual premium is required in accordance with the filed and approved Plan. An"; 5th line, changed "by the assigned carrier on a" to "only in accordance with the filed and approved Plan rules.". Delete all remaining text in the paragraph and all of (a), (b) and (c).

2904.100(d) – deleted "d)" and added "and must be paid in full, in addition to the required deposit premium, prior to binding of coverage" after "premium".

2904.110 – changed "of" to "After" in the header; changed "Within ten" to "A policy or binder shall be issued to the eligible employer and producer within 10"; added "required premium" after "receipt of the"; deleted all text after "payment".

2904.130(a), 4th line – changed "thirty" to "30".

2904.140, 6th and 7th lines -- changed "request" to "notice" twice.

2904.160(b), 1st line – changed "ten" to "10" twice.

2904.170, 2nd and 3rd lines – changed "three eights (3/8)" to "3/8".

2904.190, 3rd line – changed "on file with" to "filed with the Administrator and approved by"; 4th line, added "and a remediation program" after "procedures"; 5th line, added "and establish corrective measures as required by the remediation program" after "this Section"; added "and remediation program" after "procedures"; 7th-9th lines, deleted all text after "available to assigned carriers".

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- 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 rule currently in effect? No
- 14) Are there any rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: The rule is being amended to update or eliminate obsolete references and to revise procedures for employers seeking Assigned Risk Insurance.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

John Gatlin, Assistant Deputy Director
Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street, 5th Floor
Springfield IL 62767-0001

217/782-1786

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

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TITLE 50: INSURANCE

CHAPTER I: DEPARTMENT OF INSURANCE

SUBCHAPTER hh: WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY

PART 2904

ASSIGNED RISK PROCEDURES

Section

2904.10	Statutory Authority
2904.20	Purpose and Scope
2904.30	Written Acceptance of All Provisions of Ill. Rev. Stat. 1981, ch. 73, pars. 1081-1091 , Required of All Insurance Carriers Writing Workers' Compensation and Occupational Diseases Insurance in Illinois
2904.40	Definitions
2904.50	Designee
2904.60	Procedure for the Assignment of an Employer
2904.70	Procedure for Immediate Binding of Coverage
2904.80	Premium Notice to be Filed with the Bureau (<u>Repealed</u>)
2904.90	Commissions
2904.100	Installment Payment of Premium
2904.110	Insurance Policy to be Issued by Assigned Carrier Within Ten Days <u>after</u> of Receipt of Payment
2904.120	Final Earned Premium
2904.130	Renewal of Policies Issued Under this Part
2904.140	Policy Termination – General
2904.150	Policy Termination for Failure to Comply With Employee Welfare Laws
2904.160	Policy Termination – Hearing
2904.170	Policies of Insurance and Termination Notice to be Imprinted "Assigned Risk"
2904.180	Annual Reports Required of Mutual and Stock Insurance Pools
2904.190	Rating Standards
2904.200	Location of Servicing Office and Records
2904.210	Cost Containment
2904.220	Procedure to be Followed in the Suspension of Insurance Carriers for Non-Compliance with this Part
2904.230	Penalties
2904.240	Severability

AUTHORITY: Implementing Sections 454 and 468 of the Illinois Insurance Code [215 ILCS

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5/454 and 468] and authorized by Sections 401 and 466 of the Illinois Insurance Code [215 ILCS 5/401 and 466].

SOURCE: Adopted at 4 Ill. Reg. 49, p. 154, effective November 26, 1980; amended at 6 Ill. Reg. 7226, effective June 4, 1982; codified at 7 Ill. Reg. 3483; recodified at 20 Ill. Reg. 5732, effective April 2, 1996; amended at 38 Ill. Reg. 15611, effective July 2, 2014.

Section 2904.10 Statutory Authority

This Part is promulgated by the Director of Insurance pursuant to Sections 401 and 466 of the Illinois Insurance Code (~~Code~~) [215 ILCS 5/401 and 466]. ~~Ill. Rev. Stat. 1981, ch. 73, pars. 1013 and 1065.13), and Section 9 of the Workers' Compensation or Occupational Diseases Insurance for Rejected Employer Act (Ill. Rev. Stat. 1981, ch. 73, par. 1089) which empower the Director "...to make reasonable rules and regulations as may be necessary for making effective..." the insurance laws of this State. It is the purpose of this Part to implement the Illinois Insurance Code by defining the procedure and requirements governing the assignment to insurance carriers of employers rejected by insurance carriers for Workers' Compensation and/or Occupational Diseases Acts Coverage under the provisions of Ill. Rev. Stat. 1981, ch. 73, pars. 1065.1, 1065.15 and 1081-1091 inclusive.~~

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.20 Purpose and Scope

It is the purpose of this Part to provide the requirements and procedures for participation in the Illinois Assigned Risk Plan for Workers' Compensation ~~Act~~ [820 ILCS 305] and ~~Workers' Occupational Diseases Act~~ [820 ILCS 310] Coverage. This Part shall apply to every carrier writing or making Workers' Compensation ~~and~~ Occupational Diseases Acts insurance in the State of Illinois. This Part shall also apply to every employer seeking Assigned Risk Insurance and licensed ~~producers agents or brokers~~ acting on behalf of ~~those such~~ employers.

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.30 Written Acceptance of All Provisions of Ill. Rev. Stat. 1981, ch. 73, pars. 1081-1091, Required of All Insurance Carriers Writing Workers' Compensation and Occupational Diseases Insurance in Illinois

Every carrier writing ~~or making~~ Workers' Compensation ~~and~~ Workers' Occupational Diseases

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insurance in the State of Illinois shall file with the Director of Insurance ~~two~~^{three} copies of its written acceptance of all provisions of the ~~Act entitled, "An Act to provide insurance for employers who have been rejected by carriers respecting coverage under the~~ Workers' Compensation Act ~~and~~^{or} Workers' Occupational Diseases Act by assignment of the Department of Insurance and providing for the pooling of losses; and penalties for violation of ~~those Acts~~ this Act" (Ill. Rev. Stat. 1981, ch. 73, pars. 1081-1091 inclusive), as amended.

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.40 Definitions

As used in this Part, the following terms have the definitions set forth:

"Act" means the Workers' Compensation Act [820 ILCS 305] ~~and Workers'or~~ Occupational Diseases Act [820 ILCS 310] ~~Insurance for Rejected Employers Act.~~

"Administrator " means a qualified entity who administers the managing of the Illinois Workers' Compensation Assigned Risk Plan in compliance with the Plan and appropriate statutes/regulation. At a minimum, a qualified entity holds a valid Illinois license that enables it to develop and file its Plan and associated rates, rating plans, rules, forms and manuals.

~~"Agent or Broker" means a licensed casualty insurance agent or resident broker as defined in Section 490 of the Illinois Insurance Code. A non-resident broker may place business with the Plan only through a licensed resident agent.~~

"Assigned Carrier" means the insurance company ~~that~~^{which} the ~~Administrator~~ Illinois Council on Compensation Insurance has determined shall provide coverage to an eligible employer who has applied for an assignment pursuant to this Part.

~~"Bureau" means the Illinois Council on Compensation Insurance.~~

"Plan" means the Illinois Workers' Compensation Assigned Risk Plan as filed by the Administrator and approved by the Director.

"Producer" means a person required to be licensed under Section 500 of the Illinois Insurance Code [215 ILCS 5-500] to sell, solicit or negotiate insurance.

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"Standard Coverage" means Workers' Compensation ~~and Workers' or~~ Occupational Diseases insurance written on a basic rating plan, exclusive of deviated rating plans or retrospective rating plans.

"Termination" means the cessation of coverage by either cancellation of a policy which is in force or not renewing a policy at the end of the coverage period.

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.50 Designee

For the purpose of assisting in the assignment of an employer to a carrier, the ~~Administrator Illinois Council on Compensation Insurance, Springfield, Illinois,~~ is appointed the designee of the Department of Insurance; pursuant to Sections 401 and 468 of the Illinois Insurance Code [215 ILCS 5/401 and 468] ~~Section 9 of the Act.~~

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.60 Procedure for the Assignment of an Employer

An eligible employer seeking Assigned Risk Insurance will be bound under the Illinois Assigned Risk Plan in accordance with the following procedures:

- a) Within ~~60~~sixty days prior to application the employer must have requested and been rejected for standard coverage by two nonaffiliated insurance carriers that are licensed to write and are actively writing workers' compensation insurance within the State, one of which shall have been the carrier, if any, with which the employer was last insured for Workers' Compensation ~~and Workers' or~~ Occupational Diseases Coverage at the time of application.
- b) The ~~producer agent or broker~~ of the employer shall submit an application for assignment ~~in duplicate~~ to the ~~Administrator Illinois Council on Compensation Insurance~~. The ~~Administrator Bureau~~ shall review the content of the application. If the application is complete, the ~~Administrator Bureau will designate an insurance carrier which~~ shall calculate the estimated annual premium and notify the employer and licensed ~~producer agent or broker~~ within ~~10~~ten days as to the amount of estimated annual premium required. The application may be submitted

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online to the Administrator; however, coverage is not bound until eligibility is determined by the Administrator and the signed application is received with the appropriate premium. Coverage will be bound by the Administrator and the applicant assigned to an Assigned Carrier in accordance with the applicable Plan rules.

- c) The Upon receipt of notice of premium the employer or producer must submit the required deposit premium or pay the annual estimated premium. For applications submitted by mail, payments must be in the form of agent or broker shall forward to the assigned carrier, at the carrier's address indicated in the assignment letter, a certified check, cashier's check, or a check drawn on the producer's agent or broker's Premium Fund Trust Account payable to the Administrator assigned carrier for either the required deposit premium or the full amount of the estimated annual premium or a deposit of at least 25% of the estimated annual premium. If installment payments are requested, the deposit deposited submitted shall be the deposit required by Section 2904.100 and the Plan of this Part. The Administrator assigned carrier will bind coverage at 12:01 a.m. the first day following the date of postmark on the payment envelope, or a later date if requested in the application. For electronic applications, the total initial or deposit premium must be made electronically by credit card or electronic funds transfer (EFT). These payments may be made directly from an employer's account or their producer's account. Mailed checks are not accepted with the online application submission option. The earliest eligible effective date will be 12:01 a.m. on the day after receipt of the completed online submission, if all required information and deposit premium is received, as determined by Administrator.

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.70 Procedure for Immediate Binding of Coverage

An employer seeking Assigned Risk Insurance may be bound under the Illinois Assigned Risk Plan in accordance with the following procedures.

- a) Within 60~~sixty~~ days prior to application the employer must have requested and been rejected for standard coverage by two nonaffiliated insurance carriers licensed and actively writing workers' compensation insurance within the State, one of which shall have been the carrier, if any, with which the employer was last insured for Workers' Compensation and Workers'~~or~~ Occupational Diseases

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Coverage at the time of application.

- b) The ~~producer agent or broker~~ of the employer must contact the ~~Administrator Bureau~~ and provide the necessary information for the ~~Administrator Bureau~~ to ~~determine provide a quotation for~~ the estimated annual premium. ~~A completed and signed application must be received along with~~ After obtaining the quotation, the agent or broker shall submit an application for assignment in duplicate along with a certified check, cashier's check, or a check drawn on the agent or broker's Premium Fund Trust Account for at least 25% of the estimated annual premium or if installment payments are requested, the applicable deposit required by Section 2904.100 ~~and the Plan of this Part.~~
- c) Upon ~~receipt of a completed application and required deposit premium for the binding of immediate coverage,~~ the ~~Administrator Bureau~~ shall bind coverage in accordance with Section 2904.60(b) effective 12:01 a.m. ~~the first day following the date of postmark of the application or if the application is hand delivered to the Bureau, coverage will be effective 12:01 a.m. of the date following receipt by the Bureau.~~ The ~~Administrator Bureau~~ shall then ~~provide to notify~~ the assigned carrier ~~the complete binder package electronically the day after binding in writing as to the effective date that coverage was bound.~~ The assigned carrier shall ~~provide mail~~ to the employer and ~~producer an electronic or hard copy agent or broker a notice as to the amount of any additional premium due within 10 ten days from the date of assignment of coverage from the Administrator and assigned carrier's receipt of the required information of the assignment.~~ The employer or ~~producer agent or broker~~ shall remit ~~to the assigned carrier~~ the additional premium, or any additional deposit ~~premium payments payment due when where~~ election is made under Section 2904.100 ~~of this Part,~~ within ~~30 thirty~~ days from the date that the notice of additional premium is ~~provided to the employer and producer mailed.~~ The assigned carrier shall maintain proof ~~that of mailing, on a recognized U. S. Postal Service Form, of the notice of additional premium was provided to the employer and producer.~~ Coverage will be cancelled by the assigned carrier for nonpayment of premium in accordance with Section 143.16 of the ~~Illinois Insurance~~-Code if the additional premium, or any additional deposit premium due under Section 2904.100 ~~of this Part,~~ is not received by the assigned carrier within ~~30 thirty~~ days from the date ~~of mailing of~~ the notice of additional premium ~~was provided~~ to the employer.
- d) The ~~Administrator Bureau~~ will not bind coverage if the ~~deposit~~ premium does not

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accompany the application. If an application is submitted for the binding of immediate coverage which does not contain sufficient information to complete the assignment, the ~~Administrator~~Bureau shall advise the ~~producer~~agent or broker by telephone or electronic communication that the application is being rejected and return the appropriate premium funds provided, if any, to the original payor~~application and check to the agent or broker~~ with an explanation of the rejection to the producer. Coverage shall not be considered bound on rejected applications.

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.80 Premium Notice to be Filed with the Bureau (Repealed)

~~Within ten days of assignment of any risk, the assigned carrier shall furnish the Bureau with a copy of each notice of premium prepared pursuant to Sections 2904.60 or 2904.70 of this Part.~~

(Source: Repealed at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.90 Commissions

Any casualty ~~producer~~agent or broker who is licensed to place insurance through the facilities offered herein, shall be entitled to a commission at a rate determined by the Department of Insurance. Commissions shall be paid as follows:

- a) ~~Where the premium or premium installment is paid by the agent or broker, the agent or broker may deduct the applicable commission.~~
- ab) ~~When~~Where the payment of premium or premium installment is made by the employer directly to the assigned carrier, within 90~~ninety~~ days the assigned carrier shall pay to the ~~producer~~agent or broker of the employer the applicable amount of commission due.
- be) If there has been no commission paid on an expiring policy or existing policy, and the employer desires that a commission be paid to a producer~~an agent or broker~~, the employer shall notify the assigned carrier in writing, or the ~~producer~~agent or broker may submit to the assigned carrier a letter of authority signed by the employer appointing the agent or broker as such for the insurance. If the appointment is received by the assigned carrier after the date of renewal, the

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commission shall be paid on a pro rata basis for the remainder of the policy term.

- cd) If there has been a commission paid on a policy, the ~~producer agent or broker~~ of record may be changed upon the request of the employer effective upon the next renewal of the policy.

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.100 Installment Payment of Premium

Policies with an estimated premium of \$1,000 or less shall be paid in full. Payment of the estimated annual premium is required in accordance with the filed and approved Plan. An~~When the employer's estimated annual premium, as quoted in the notice of premium, is in excess of \$1,000, an~~ installment payment plan may be requested by the employer and will be made available only in accordance with the filed and approved Plan rules.~~by the assigned carrier on a monthly or a quarterly basis, as follows: a) If the estimated annual premium is less than \$10,000, installment payments will be available on a quarterly basis. Payment shall be made by a deposit of at least 40% of the estimated annual premium, and the balance to be paid in three (3) equal quarterly installments. b) Where the estimated annual premium is \$10,000 or more, installment payments will be available on a monthly basis. Payment shall be made by a deposit of at least 25% of the estimated annual premium, and the balance to be paid in eleven (11) equal monthly installments. c) The total payment under an installment plan shall not exceed 100% of the estimated annual premium quoted in the notice of premium. Payment by an installment plan shall not preclude prepayment at any time of the outstanding balance. The Illinois Workers' Compensation Commission surcharge is not a premium and must be paid in full, in addition to the required deposit premium, prior to binding of coverage.~~

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.110 Insurance Policy to be Issued by Assigned Carrier Within Ten Days Afterof Receipt of Payment

A policy or binder shall be issued to the eligible employer and producer within 10~~Within ten~~ days after~~of~~ receipt of the required premium payment ~~the assigned carrier shall issue a policy or binder to the employer and agent or broker.~~

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

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Section 2904.130 Renewal of Policies Issued Under this Part

- a) The assigned carrier shall, ~~sixty (60)~~ days prior to the expiration of the policy, submit to the employer and ~~producer agent or broker~~ a notice of premium for renewal of the policy. If the renewal premium is not received by the assigned carrier ~~30~~~~thirty~~ days prior to the expiration of the policy, the assigned carrier shall issue a notice of expiration.
- b) If the renewal premium is received prior to the expiration date, the policy shall be renewed without lapse in coverage. If the renewal premium is received within 30 days after the expiration date, the policy shall be renewed effective 12:01 a.m. on the first day following the date of postmark on the payment envelope. If the renewal premium is received more than 30 days after the expiration date, the premium may be refused and the employer may apply for assignment pursuant to Sections 2904.60 or 2904.70 ~~of this Part~~. The assigned carrier may accept renewal premiums more than 30 days after the expiration of the policy, which renewal shall be effective 12:01 a.m. on the first day following the date of postmark on the payment envelope.

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.140 Policy Termination – General

The assigned carrier may terminate a policy issued under this Part as permitted by law. ~~a) Every assigned carrier issuing a policy of Workers' Compensation insurance pursuant to this Part shall request written approval from the Illinois Department of Insurance for the termination of such policy. The termination request shall be made in writing at least sixty (60) days prior to the proposed termination date. A copy of the request must be sent to the employer, the employer's agent or broker of record, the Department and the Bureau. b) The termination~~ notice request shall indicate whether the policy is being cancelled or nonrenewed. The termination notice request shall include the proposed date of termination, the reason or reasons for the termination, and all other information required by law. The termination notice request shall notify the employer of the hearing procedures set forth in Section 2904.160 ~~of this Part~~. ~~c) The Department shall review the termination request for compliance with this Part and all applicable laws. The Department shall approve or disapprove the termination request within 45 days, unless a hearing is requested pursuant to Section 2904.160 of this Part.~~

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

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Section 2904.160 Policy Termination – Hearing

- a) An employer who wishes to object to ~~the~~ reason or reasons for termination shall, within ~~10~~~~ten~~ days after receipt of ~~the~~~~such~~ notice of termination, mail or deliver to the Director of Insurance a written request for a hearing ~~that~~~~which~~ shall clearly state the basis for the objection. This Section shall not apply to cancellations at the employer's request or to cancellations in the case of nonpayment of premium as defined in Section 143.13 of the Code. The notice of cancellation or nonrenewal to which this Section applies shall advise the named insured of his or her right to appeal and the procedure to follow for the appeal.
- b) Within ~~10~~~~ten~~ days after receipt of the request for a hearing and upon ~~10~~~~ten~~ days notice to the parties, the Director shall convene a hearing. Within ~~20~~~~twenty~~ days ~~after~~~~of~~ the conclusion of the hearing, the Director shall issue his ~~or her~~ written findings to the parties. The policy will remain in force until ~~such time as~~ the Director has given his ~~or her~~ findings. If the Director finds for the employer, he ~~or she~~ shall order the assigned carrier to rescind its notice of termination. If the Director finds for the assigned carrier, he ~~or she~~ shall order that the termination be effective ~~30~~~~thirty~~ days from the date of his ~~or her~~ order. The assigned carrier is entitled to a premium for any extension of coverage and ~~the~~~~such~~ extension shall be contingent upon the payment of the premium.

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.170 Policies of Insurance and Termination Notice to be Imprinted "Assigned Risk"

All assigned carriers shall stamp or print on all policies or binders of Insurance or Termination Notices filed pursuant to this Part the words "Assigned Risk" in letters not less than ~~three eighths~~ ($\frac{3}{8}$) of an inch high.

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.190 Rating Standards

All assigned carriers shall rate all policies issued under this Part in accord with the ~~National Council on Compensation Insurance~~ Manuals of Rules and Rates filed with the the Administrator

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~~and approved by~~ ~~file with~~ the Department of Insurance. The ~~Administrator~~~~Bureau~~ shall establish audit procedures and a remediation program to evaluate an assigned carrier's compliance with this Section and establish corrective measures as required by the remediation program. The audit procedures and remediation program established pursuant to this Section shall be made available to assigned carriers. ~~Any assigned carrier which, over any six-month period, exceeds a rating standards error ratio of ten percent, shall become ineligible to act as a servicing carrier in the Assigned Risk Plan for a period of one year.~~

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.220 Procedure to be Followed in the Suspension of Insurance Carriers for Non-Compliance with this Part

If any carrier refuses or neglects to comply with any of the provisions of this Part, the Director shall pursue the suspension of the Certificate of Authority of that carrier, ~~pursuant to Section 10 of the Act.~~

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

Section 2904.230 Penalties

Any carrier ~~or, producer, agent or broker~~ failing to comply with the requirements of this Part shall be subject to ~~such~~ penalties as may be appropriate under the ~~Code Insurance Laws of Illinois (Illinois Revised Statutes, Chapter 73).~~

(Source: Amended at 38 Ill. Reg. 15611, effective July 2, 2014)

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NOTICE OF ADOPTED RULES

- 1) Heading of the Part: Public Information, Rulemaking and Organization
- 2) Code Citation: 2 Ill. Adm. Code 1000
- 3)

<u>Section Numbers</u> :	<u>Adopted Action</u> :
1000.10	New Section
1000.15	New Section
1000.20	New Section
1000.30	New Section
1000.100	New Section
1000.105	New Section
1000.110	New Section
1000.120	New Section
1000.130	New Section
1000.200	New Section
1000.205	New Section
1000.210	New Section
1000.215	New Section
1000.230	New Section
1000.TABLE A	New Section
- 4) Statutory Authority: Implementing Sections 5-10 and 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-10 and 5-15] and authorized by Sections 3-2.5-20 and 3-2-5 of the Unified Code of Corrections [730 ILCS 5/3-2.5-20 and 3-2-5]
- 5) Effective Date of Rules: July 3, 2014
- 6) Do these rules contain an automatic repeal date? No
- 7) Do these rules contain incorporations by reference? No
- 8) A copy of the adopted rules, including any material incorporated by reference, is on file in the Illinois Department of Juvenile Justice's principal office and is available for public inspection.
- 9) Notices of Proposed Published in the *Illinois Register*: Section 5-15 of the IAPA allows agencies to adopt required organizational rules when they are published in the *Illinois Register* and a certified copy of the rules is filed with the Secretary of State.

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- 10) Has JCAR issued a Statement of Objection to these rules: No
- 11) Differences between proposal and final version: This rule is exempt from the public comment period and the JCAR review period, as authorized by Section 5-15(b) of the Illinois Administrative Procedure Act [5 ILCS 100/5-15(b)].
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? This rule is exempt from the public comment period and the JCAR review period, as authorized by Section 5-15(b) of the Illinois Administrative Procedure Act [5 ILCS 100/5-15(b)].
- 13) Will this rule replace any emergency rule currently in effect? No
- 14) Are there any proposed amendments pending on this Part? No
- 15) Summary and Purpose of Rules: Section 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-15] requires each agency to adopt rules on the following: 1) *a description of the current organization of the agency including charts of such organization;* 2) *procedures on public access to subjects, programs, and activities of the agency;* 3) *tables of contents, indexes, reference tables, and other materials to aid users in finding and using the agency's collection of rules currently in force;* 4) *the rulemaking procedures of the agency including any flow charts depicting such;* 5) *a location for public inspection of incorporated reference materials.*
- 16) Information and questions regarding these Adopted Rules shall be directed to:
- Beth Compton
Chief Legal Counsel
Illinois Department of Juvenile Justice
1301 Concordia Court, P.O. Box 1927
Springfield, Illinois 62794-9277
- 217-557-1030
- 17) Does this rule require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code [30 ILCS 500/5-25]? No

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

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NOTICE OF ADOPTED RULES

TITLE 2: GOVERNMENTAL ORGANIZATION
SUBTITLE D: CODE DEPARTMENTS
CHAPTER XII: DEPARTMENT OF JUVENILE JUSTICE

PART 1000
PUBLIC INFORMATION, RULEMAKING AND ORGANIZATION

SUBPART A: PUBLIC INFORMATION

Section	
1000.10	Applicability
1000.15	Definitions
1000.20	Public Requests
1000.30	Public Submissions

SUBPART B: RULEMAKING

Section	
1000.100	Applicability
1000.105	Responsibilities
1000.110	Definitions
1000.120	Procedure
1000.130	Public Hearings

SUBPART C: ORGANIZATION

Section	
1000.200	Applicability
1000.205	Definitions
1000.210	Department Organization
1000.215	Central Office Locations
1000.230	Juvenile Correctional Facilities

1000.TABLE A	Department Organization
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AUTHORITY: Implementing Sections 5-10 and 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-10 and 5-15] and authorized by Sections 3-2.5.20 and 3-2-5 of the Unified Code of Corrections [730 ILCS 5/3-2.5-20 and 3-2-5].

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SOURCE: Adopted at 38 Ill. Reg.15627, effective July 3, 2014.

SUBPART A: PUBLIC INFORMATION

Section 100.10 Applicability

This Subpart applies to any interested persons seeking or submitting information regarding subjects, programs, and activities of the Department of Juvenile Justice. However, any interested persons seeking access to public records in the possession of the Department shall comply with 2 Ill. Adm. Code 1010.

Section 100.15 Definitions

"Department" means the Department of Juvenile Justice.

"Director" means the highest ranking official of the Department of Juvenile Justice.

Section 100.20 Public Requests

- a) Any interested person should submit a request for information in writing. The request should include a complete description of the information requested, the reason for the request, and when applicable, timing requirements. Requests, other than requests for public records, should be directed to:

Director
Illinois Department of Juvenile Justice
1301 Concordia Court
P.O. Box 19277
Springfield, Illinois 62794-9277

- b) The Department shall respond to such requests within 10 working days of receipt, whenever possible. However, any interested persons seeking access to public records in the possession of the Department shall be directed to comply with 2 Ill. Adm. Code 1010.

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- c) When confidential information is requested, or whenever release of information is limited or prohibited by statute, court order, or by any provision of 20 Ill. Adm. Code: Chapter I, the requestor shall be notified.

Section 1000.30 Public Submissions

Any interested person may submit comments and recommendations regarding subjects, programs, and activities of the Department in writing to:

Director
Illinois Department of Juvenile Justice
1301 Concordia Court
P.O. Box 19277
Springfield, Illinois 62794-9277

SUBPART B: RULEMAKING

Section 1000.100 Applicability

This Subpart applies to all divisions, offices, and program sites within the Department of Juvenile Justice and to any other interested persons.

Section 1000.105 Responsibilities

- a) Unless otherwise specified, the Director or members of the Executive Staff may delegate responsibilities stated in this Part to another person or persons or designate another person or persons to perform the duties specified.
- b) No other individual may routinely perform duties whenever a Section in this Part specifically states the Director or members of the Executive Staff shall personally perform the duties. However, the Director or members of the Executive Staff may designate another person or persons to perform the duties during periods of their temporary absence or in an emergency.

Section 1000.110 Definitions

Statutory definitions shall apply to terms used in the Department rules, unless otherwise defined. For purposes of these rules:

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"Department" means the Illinois Department of Juvenile Justice.

"Department rules" means 2 Ill. Adm. Code 1000, 4 Ill. Adm. Code 530, 20 Ill. Adm. Code: Chapter IX, and any other rules adopted by the Department in accordance with the Illinois Administrative Procedure Act [5 ILCS 100/1-1 et seq.].

"Director" means the highest ranking official of the Department.

"Part" means a unified set of rules.

"Section" means a single rule.

"Subpart means a unified set of rules within a Part.

"Youth" means persons committed to the Department who have not been discharged, including those persons who have been released on aftercare release.

Section 100.120 Procedure

- a) Rules may be proposed by the Director and members of the Executive Staff in consultation with their staff. However, only rules approved by the Director shall be promulgated.
- b) Any interested person may petition the Director to adopt, amend, or repeal a rule.
 - 1) The preferred form of address of the petition is:

Director
Attn: Policy and Directives Unit
Illinois Department of Juvenile Justice
1301 Concordia Court
P.O. Box 19277
Springfield, Illinois 62794-9277

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- 2) The petition shall contain a clear statement of reasons for the proposed rule, amendment, or repeal and the exact language of the suggested new rule or amendment.
 - 3) The petitioner shall be advised in writing, within 30 days whenever possible, of the decision in regard to the petition.
- c) Rules shall be reviewed on an on-going basis and shall be adopted, amended, or repealed as necessary to maintain Department rules in accord with State and federal law and to appropriately address the concerns of Department facilities, staff, offenders, and the public.
 - d) Prior to initiation of formal rulemaking procedures pursuant to the Illinois Administrative Procedure Act [5 ILCS 100/1-1 et seq.], proposed rulemaking:
 - 1) Shall be reviewed and approved by appropriate Department staff.
 - 2) May, upon the approval of the Director, be reviewed by individuals or organizations other than Department staff.
 - e) Rules adopted by the Department shall be made available to employees, youth, and the public.
 - f) Rules adopted by the Department shall be available for public inspection during normal working hours at the Policy and Directives Unit, 1301 Concordia Court, Springfield, Illinois. A request to inspect rules should be made in advance when possible via telephone at 217/557-1030.

Section 1000.130 Public Hearings

- a) The Director may conduct public hearings on proposed rulemaking whenever the interest of the State would be best served by such proceedings or as otherwise required by law.
- b) A formal notice of a public hearing will be published in the Illinois Register at least 10 days prior to the hearing. The notice shall include the date, time, and place of the proceedings.

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- c) Minutes of public hearings shall be recorded and shall be available for public inspection at the Policy and Directives Unit, 1301 Concordia Court, Springfield, Illinois.

SUBPART C: ORGANIZATION

Section 1000.200 Applicability

This rule applies to all divisions, offices, and program sites within the Department of Juvenile Justice.

Section 1000.205 Definitions

"Department" means the Department of Juvenile Justice.

"Director" means the highest ranking official of the Department of Juvenile Justice.

Section 1000.210 Department Organization

- a) The Department shall have bureaus, divisions, and offices as designated by the Director.
- b) The organization of the Department is illustrated in Table A. The Juvenile Advisory Boards and the School District #428, Board of Education, illustrated on this table by broken lines, are shown to reflect the advisory capacity and the interaction with the Department. These Boards are not within the organizational structure of the Department.

Section 1000.215 Central Office Locations

- a) Concordia Complex
1301 Concordia Court
P.O. Box 19277
Springfield, Illinois 62794-9277
Telephone: 217/557-1030
- b) State of Illinois Center

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100 West Randolph St., Suite 4-200
Chicago, Illinois 60601-3219
Telephone: 312/814-3017

Section 1000.230 Juvenile Correctional Facilities

The following are designated as the youth centers for juvenile offenders. Unless otherwise noted, the facilities listed are for males.

a) Youth Centers

Illinois Youth Center-Chicago, Chicago
Illinois Youth Center-Harrisburg, Harrisburg
Illinois Youth Center-Kewanee, Kewanee
Illinois Youth Center-Pere Marquette, Grafton
Illinois Youth Center-St. Charles, St. Charles
Illinois Youth Center-Warrenville, Warrenville (female)

b) Reception and Classification Units

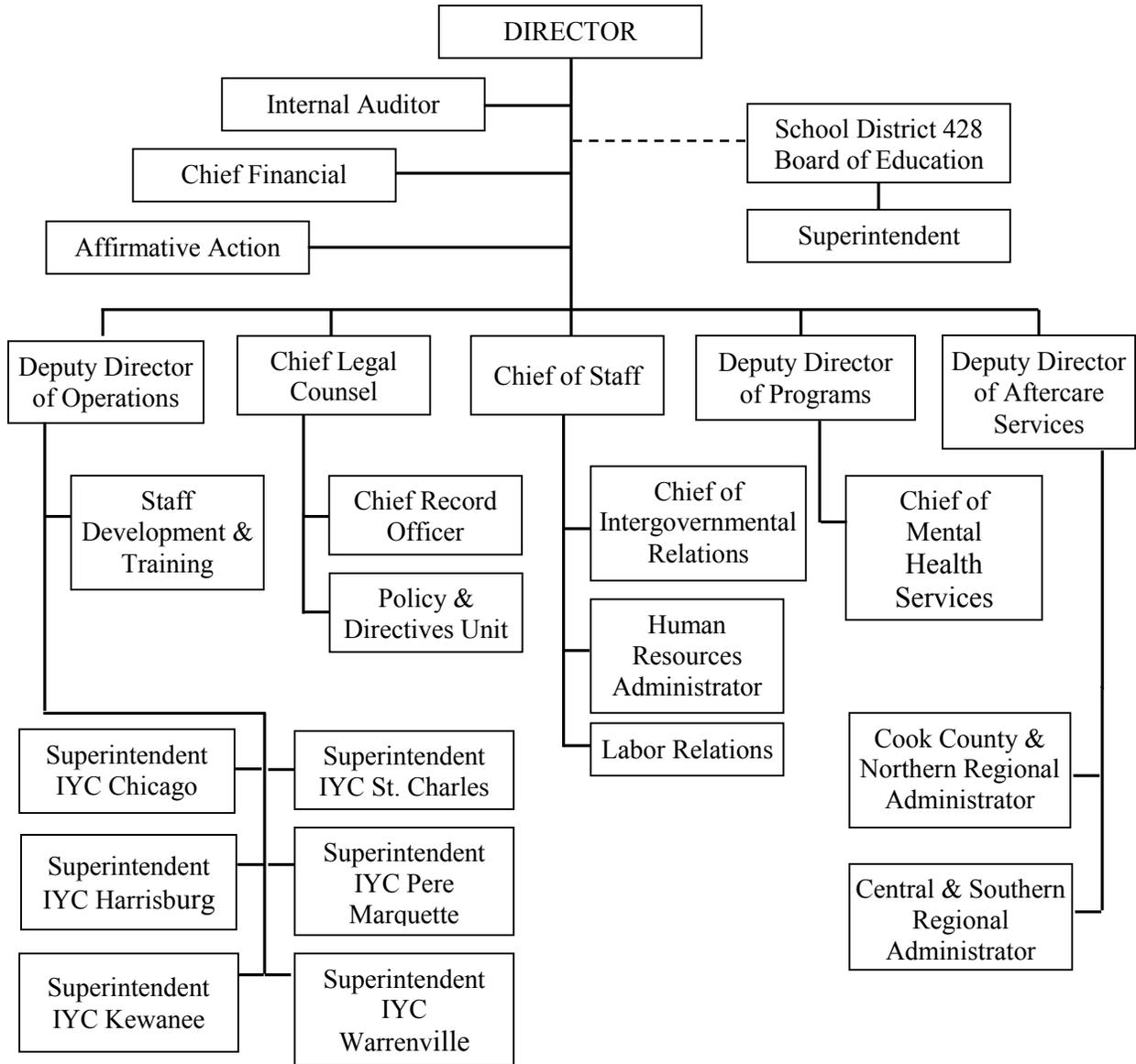
Juvenile Reception and Classification Units are established within the following youth centers:

St. Charles (male)
Harrisburg (male)
Warrenville (female)

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Section 1000.TABLE A Department Organization



SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Uniform Commercial Code
- 2) Code Citation: 14 Ill. Adm. Code 180
- 3)

<u>Section Numbers</u> :	<u>Adopted Action</u> :
180.12	Amendment
180.15	Amendment
180.17	Amendment
- 4) Statutory Authority: Implementing and authorized by Article 9 of the Uniform Commercial Code [810 ILCS 5/Art. 9]
- 5) Effective Date of Rule: July 1, 2014
- 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 rule, 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 published in the Illinois Register: March 28, 2014, 38 Ill. Reg. 7088
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: No substantive changes were made during the First Notice period. All technical changes recommended by JCAR were made.
- 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 rule currently in effect? No
- 14) Are there any rulemakings pending on this Part? No
- 15) Summary and Purpose of Rulemaking: Updates format requirements with respect to debtor and secured party names and debtor addresses. Removes outdated references to

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information required of business entities. Updates terminology regarding data entry procedures for individual names.

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

Michelle Nijm
Assistant General Counsel
100 W. Randolph, Ste. 5-400
Chicago IL 60601

312/814-7246

- 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 500/5-25]? No

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

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TITLE 14: COMMERCE
SUBTITLE A: REGULATION OF BUSINESS
CHAPTER I: SECRETARY OF STATEPART 180
UNIFORM COMMERCIAL CODE

Section

180.10	Definitions
180.11	Tender of UCC Records for Filing/Search Request Delivery
180.12	Forms
180.13	Filing Fees/Methods of Payment/Overpayment and Underpayment Policies
180.14	Public Record Services
180.15	Acceptance and Refusal of Records
180.16	UCC Information Management System
180.17	Filing and Data Entry Procedures
180.18	Search Requests and Reports
180.19	XML Documents

AUTHORITY: Implementing and authorized by Article 9 of the Uniform Commercial Code [810 ILCS 5/Art. 9].

SOURCE: Adopted at 12 Ill. Reg. 17431, effective November 1, 1988; amended at 18 Ill. Reg. 2101, effective February 1, 1994; amended at 20 Ill. Reg. 7064, effective May 8, 1996; emergency amendment at 25 Ill. Reg. 9984, effective July 23, 2001, for a maximum of 150 days; emergency expired December 19, 2001; amended at 26 Ill. Reg. 7448, effective May 2, 2002; amended at 29 Ill. Reg. 19704, effective November 28, 2005; amended at 30 Ill. Reg. 12977, effective July 11, 2006; amended at 31 Ill. Reg. 8559, effective June 15, 2007; amended at 32 Ill. Reg. 12057, effective July 16, 2008; amended at 34 Ill. Reg. 1411, effective February 1, 2010; amended at 36 Ill. Reg. 3931, effective February 27, 2012; amended at 37 Ill. Reg. 15745, effective September 19, 2013; amended at 38 Ill. Reg. 15638, effective July 1, 2014.

Section 180.12 Forms

The forms prescribed by Section 9-521 of the UCC [810 ILCS 5/9-521] shall be accepted by the filing office. Forms approved by the UCC Division shall be accepted. Copies of the approved forms are available on the Secretary of State's website at www.cyberdriveillinois.com.

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- a) In order to insure the legibility after records are scanned into the imaging system of the UCC Division, the information on each record submitted shall be typewritten or computer generated typeface. The names and addresses of the debtor and the secured party shall be in all capital or mixed case letters with a font size of at least 10 point Helvetica/Swiss style font.
- b) The remitter shall submit two copies of each record, along with a self-addressed stamped envelope. The UCC Division shall retain one copy for its records and return one copy to the remitter as an acknowledgement. If only one copy is submitted, it will be stamped "No Acknowledgement Received" and the UCC Division will retain that copy for its records. There will be no acknowledgement copy returned to the remitter.
- c) All UCC records must contain the full legal name and address of the debtor and indicate whether the debtor is an individual or an organization. As used in this Section, address is deemed to include street address, route number or P.O. Box, city, state and zip code. ~~If the debtor is an organization, the record must include the type of organization, the jurisdiction of the organization, and the organizational identification number of the debtor. Records that do not contain this information will not be accepted for filing. The disclosure on the records of the social security number or tax identification number of the debtor is voluntary only, and records will be accepted for filing without the number.~~ The disclosure on the records of the social security number or tax identification number of the debtor is non-required information and, due to the sensitive nature of the information, it will be redacted from the record.
- d) When submitting a UCC-3 Amendment to delete more than a single debtor name, a separate UCC-3 Amendment form must, pursuant to Section 9-512 of the UCC, be completed for each debtor name to be deleted. A separate fee must also be tendered for each UCC-3 Amendment form submitted.
- e) When submitting a UCC-3 Amendment pursuant to Section 9-512 of the UCC, only one UCC-3 Amendment type per form will be permitted. A separate fee must also be tendered for each UCC-3 Amendment form submitted.

(Source: Amended at 38 Ill. Reg. 15638, effective July 1, 2014)

Section 180.15 Acceptance and Refusal of Records

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- a) Role of Secretary. The duties and responsibilities of the Secretary with respect to the administration of the UCC are ministerial. In accepting for filing or refusing to file a UCC record, the Secretary does none of the following:
- 1) Determine the legal sufficiency or insufficiency of a record.
 - 2) Determine that a security interest in collateral exists or does not exist.
 - 3) Determine that information in the record is correct or incorrect, in whole or in part.
 - 4) Create a presumption that information in the record is correct or incorrect, in whole or in part.
- b) Grounds for refusal. In addition to the grounds listed in Section 9-516 of the UCC [810 ILCS 5/9-516], allowing the filing officer to refuse a UCC record, the filing officer shall refuse a UCC record if the record contains more than one debtor, secured party or assignee name or address and some names or addresses are missing or illegible, or no address is given in the address field. As used in this Section, address is deemed to include street address, city, state and postal code.
- 1) Deadline for filing a continuation statement. The first day on which a continuation statement may be filed is the date corresponding to the date upon which the financing statement would lapse, six months preceding the month in which the financing statement would lapse. If there is no such corresponding date, the first day on which a continuation may be filed is the last day of the sixth month preceding the month in which the financing statement would lapse.
 - 2) Last day permitted. The last day on which a continuation statement may be filed is the last business day of maturity before the lapse date of the UCC. If the last business day on which the UCC matures falls on a holiday or weekend, the filing office must receive the continuation on the last business day prior to the lapse date.
- c) Procedure upon refusal. Except as provided in Section 180.13 of this Part, if the filing officer finds grounds to refuse a UCC record, the filing officer shall return

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the record to the remitter and shall return the filing fee.

- d) Notification of defects. Nothing in this Section prevents a filing officer from communicating to a filer or a remitter that the filing officer noticed apparent potential defects in a UCC record, whether or not it was filed or refused for filing. However, the filing office is under no obligation to do so and may not, in fact, have the resources to do so, or to identify such defects. The responsibility for the legal effectiveness of filing rests with filers and remitters and the filing office bears no responsibility for legal effectiveness.
- e) Refusal errors. If a secured party or a remitter demonstrates to the satisfaction of the filing officer that a UCC record that was refused for filing should not have been, the filing officer will file the UCC record with a filing date and time assigned when the filing occurs. The filing officer will also file a filing officer statement that states the effective date and time of filing, which shall be the date and time the UCC record was originally tendered for filing.
- f) Transmitting utility rejections. If a UCC Financing Statement submitted as a Transmitting Utility is rejected because it does not meet the definitions of a Transmitting Utility under the provisions of 810 ILCS 5/9-102(80), it may be resubmitted with proper verification that a Transmitting Utility exists.
 - 1) Rejected UCCs submitted as a Transmitting Utility will be reviewed by General Counsel and the Director of the Department of Business Services to determine that a valid reason exists for the rejection.
 - 2) Upon receipt of the resubmitted UCC Financing Statement with proper verification that a Transmitting Utility exists, the submitted documents will be accepted and given the same received stamped date as the original date of filing.

(Source: Amended at 38 Ill. Reg. 15638, effective July 1, 2014)

Section 180.17 Filing and Data Entry Procedures

- a) Errors of the filing office. The filing officer may correct the errors of filing office personnel in the UCC information management system at any time. If the correction occurs after the filing officer has issued a certification date, the filing

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officer shall file a filing officer correction statement in the UCC information management system identifying the record to which it relates and the date of the correction and explaining the nature of the corrective action taken. The record shall be preserved as long as the record of the initial financing statement is preserved in the UCC information management system.

- 1) In the case of a data entry error that caused the record in the UCC information management system to be different from the originally submitted document, the record indexed in the management system will be corrected to correspond with the originally submitted record.
 - 2) In the case of an error on the part of the filer that is noticed after a certification date has been issued, the filing office is under no obligation to make the corrections. It is the responsibility of the filer to correct any errors pursuant to Sections 9-511, 9-512 and 9-518 of the UCC [810 ILCS 5/9-511, 9-512 and 9-518].
- b) Data entry of names – designated fields. A filing should designate whether a name is a name of an individual or an organization. If the name is that of an individual, the first, middle and last names and any suffix shall be given.
- 1) Organization names. Organization names are entered into the UCC information management system exactly as set forth in the UCC record, even if it appears that multiple names are set forth in the record, or if it appears that the name of an individual has been included in the field designated for an organization name.
 - 2) Individual names. On a form that designates separate fields for the individual's surname, first personal name, and additional names/initials, first, middle, and last names and any suffix, the filing officer enters the names into the respective fields~~field, last name first, then first name, middle name, and any suffix~~ in the UCC information management system exactly as set forth on the form.
 - 3) Designated fields encouraged. The filing office encourages the use of forms that designate separate fields for individual and organization names and separate fields for first, middle, and last names and any suffix. Such forms diminish the possibility of filing office error and help assure that

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filers' expectations are met. However, filers should be aware that the inclusion of names in an incorrect field or failure to transmit names accurately to the filing office may cause filings to be ineffective.

- c) Notice of bankruptcy. The filing officer shall take no action upon receipt of a notification, formal or informal, of a bankruptcy proceeding involving a debtor named in the UCC information management system.

(Source: Amended at 38 Ill. Reg. 15638, effective July 1, 2014)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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- 1) Heading of the Part: Medical Assistance Programs
- 2) Code Citation: 89 Ill. Adm. Code 120
- 3) Section Numbers: Proposed Action:
 120.308 Amendment
 120.380 Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date: July 7, 2014
- 6) If this emergency rule is to expire before the end of the 150-day period, please specify the date on which it is to expire: None
- 7) Date Filed with the Index Department: July 7, 2014
- 8) A copy of the emergency rule, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Reason for Emergency: PA 98-651 added 5 ILCS 100/5-45(r), which authorizes emergency rulemaking to implement its provisions of that Public Act. PA 98-651 deemed that emergency rulemaking was necessary for the public interest, safety, and welfare.
- 10) Complete Description of the Subjects and Issues Involved: Pursuant to PA 98-651, this emergency rule makes changes to the long term application process.
- 11) Are there any other proposed rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
120.324	Amendment	37 Ill. Reg. 12302; August 2, 2013
120.10	Amendment	38 Ill. Reg. 7426; April 4, 2014
120.12	Amendment	38 Ill. Reg. 7426; April 4, 2014
120.32	Amendment	38 Ill. Reg. 7426; April 4, 2014
120.64	Amendment	38 Ill. Reg. 7426; April 4, 2014

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- 12) Statement of Statewide Policy Objective: This emergency rule neither creates nor expands any State mandate affecting units of local government.
- 13) Information and questions regarding this emergency rule shall be directed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

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

The full text of the Emergency Rule begins on the next page:

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NOTICE OF EMERGENCY 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 Eligibility for Pregnant Women and Children
- 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 Determination of Eligibility for Cases Subject to Modified Adjusted Gross

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- Income (MAGI) Methodology
120.65 Department of Mental Health and Developmental Disabilities (DMHDD)
Licensed Community – Integrated Living Arrangements (Repealed)

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)

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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)
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

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120.309 Caretaker Relative

120.310 Citizenship

120.311 Residence

120.312 Age

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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
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)

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- 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
- EMERGENCY
- 120.381 Exempt Resources
120.382 Resource Disregard
120.383 Deferral of Consideration of Assets
120.384 Spenddown of Resources
120.385 Factors Affecting Eligibility for Long Term Care Services
120.386 Property Transfers Occurring On or Before August 10, 1993
120.387 Property Transfers Occurring On or After August 11, 1993 and Before January 1, 2007
120.388 Property Transfers Occurring On or After January 1, 2007
120.390 Persons Who May Be Included In the Assistance Unit
120.391 Individuals Under Age 18 Who Do Not Qualify For AFDC/AFDC-MANG And Children Born October 1, 1983, or Later
120.392 Pregnant Women Who Would Not Be Eligible For AFDC/AFDC-MANG If The Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
120.393 Pregnant Women And Children Under Age Eight Years Who Do Not Qualify As Mandatory Categorically Needy Demonstration Project
120.395 Payment Levels for MANG (Repealed)
120.399 Redetermination of Eligibility
120.400 Twelve Month Eligibility for Persons under Age 19

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)

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- 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 (P.L. 109-171).

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

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amendment at 5 Ill. Reg. 10124, effective October 1, 1981; preemptory 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; preemptory amendment at 5 Ill. Reg. 11647, effective October 16, 1981; preemptory 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; preemptory amendment at 6 Ill. Reg. 2452, effective February 11, 1982; preemptory amendment at 6 Ill. Reg. 6475, effective May 18, 1982; preemptory 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 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; preemptory 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

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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. 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;

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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; 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

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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; preemptory amendment at 32 Ill. Reg. 7212, effective April 21, 2008; preemptory amendment suspended at 32 Ill. Reg. 8450, effective May 20, 2008; preemptory 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; preemptory amendment at 32 Ill. Reg. 18889, effective November 18, 2008; preemptory 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; preemptory 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 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; emergency amendment at 37 Ill. Reg. 15976, effective October 1, 2013, for a maximum of 150 days; emergency amendment to emergency rule at 38 Ill. Reg. 1139, effective January 1, 2014, for a maximum of 150 days; emergency amendment to emergency rule at 38 Ill. Reg. 2925, effective January 10, 2014, for a maximum of 150 days; emergency amendments effective January 1 and January 10, 2014 repealed by emergency rule at 38 Ill. Reg. 7368, effective March 24, 2014, for the remainder of the 150 day effective periods of each of the emergency rules; amended at 38 Ill. Reg. 5967, effective February 26, 2014; emergency amendment at 38 Ill. Reg. 7650, effective March 24, 2014, for a maximum of 150 days; emergency amendment at 38 Ill. Reg. 15646, effective July 7, 2014, for a maximum of 150 days.

SUBPART H: MEDICAL ASSISTANCE – NO GRANT (MANG) ELIGIBILITY FACTORS

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Section 120.308 Client Cooperation**EMERGENCY**

- a) As a condition of eligibility, clients must cooperate:
 - 1) in the determination of eligibility;
 - 2) with Department programs conducted for the purposes of acquisition or verification of information upon which eligibility may depend; and
 - 3) in applying for all financial benefits for which they may qualify and to avail themselves of those benefits at the earliest possible date.
- b) Clients are required to avail themselves of all potential income and resources and to take appropriate action to receive such resources, including those described under Section 120.388(d)(2) of this Part.
- c) When eligibility cannot be conclusively determined because the individual is unwilling or fails to provide essential information or to consent to verification, the client is ineligible.
- d) At screening, applicants shall be informed, in writing, of any information they are to provide at the eligibility interview.
- e) At the eligibility interview or at any time during the application process, when the applicant is requested to provide information in his or her possession, the Department will allow 10 days for the return of the requested information. The first day of the 10 day period is the calendar day following the date the information request form is sent or given to the applicant. The last day of the 10 day period shall be a work day and is to be indicated on the information request form. If the applicant does not provide the information by the date on the information request form, the application shall be denied on the following work day.
- f) At the eligibility interview or at any time during the application process, when the applicant is requested to provide third party information, the Department shall allow 10 calendar days for the return of the requested information or for

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verification that the third party information has been requested. The first day of the 10 day period is the calendar day following the date the information request form is sent or given to the applicant. The last day of the 10 day period shall be a work day and will be indicated on the information request form. If the applicant does not provide the information or verification that the information was requested by the date on the information request form, the application shall be denied on the following work day.

- 1) Third party information is defined as information that must be provided by someone other than the applicant. An authorized representative or person applying on another's behalf is not a third party, but is treated as if he or she were the applicant.
- 2) The Department shall advise clients of the need to provide written verification of third party information requests and the consequences of failing to provide that verification.
- 3) If the applicant requests an extension either verbally or in writing in order to obtain third party information and provides written verification of the request for the third party information, such as a copy of the request that was sent to the third party, an extension of 45 days from the date of application shall be granted. The first day of the 45 day period is the calendar day following the date of application. The 45th day must be a work day.
 - A) For long-term care (LTC) applicants, the Department shall send a request for information about current resources or resources transferred in the look-back period to the client and the authorized representative, if any and the facility, if known.
 - B) For LTC applicants, when requested by applicant, his or her spouse, the authorized representative, or the facility in which the applicant lives, the Department shall allow:
 - i) an extension of up to 30 days to provide verification about current resources or resources transferred under the look-back period described in Section 120.387 or 120.388; and

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Section 120.380 Resources**EMERGENCY**

- 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:
 - A) ~~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.
 - B) [Effective June 16, 2014, clients and applicants who receive Supplemental Security Income \(SSI\) payments or who were](#)

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receiving SSI when they entered a nursing home or the supported living program or initiated other long term support services are considered to have their current resources verified.

C) Effective June 16, 2014, individuals who have verified income at or below 100% FPL and report resources at or below the appropriate resource disregard in Section 120.382 or 120.510 are considered to have their current resources verified, unless there is a specific reason to question the value of the 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, resources and exemptions available to a person as of the first day of each of the backdated months for which eligibility is sought.
 - 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

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- 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
 - 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

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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
 - 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

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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 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 by emergency rulemaking at 38 Ill. Reg. 15646, effective July 7, 2014, for a maximum of 150 days)

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NOTICE OF EMERGENCY AMENDMENT

- 1) Heading of the Part: Covering All Kids Health Insurance Program
- 2) Code Citation: 89 Ill. Adm. Code 123
- 3) Section Number: 123.200 Emergency Action:
Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5]
- 5) Effective Date: July 7, 2014
- 6) If this emergency rule is to expire before the end of the 150-day period, please specify the date on which it is to expire: None
- 7) Date Filed with the Index Department: July 7, 2014
- 8) A copy of the emergency amendment, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Reason for Emergency: PA 98-104 authorizes emergency rulemaking pursuant to 5 ILCS 100/5-45(q), which provides for the expeditious and timely implementation of the provisions of Article 7 of PA 98-104 as necessary for the public interest, safety, and welfare.
- 10) Complete Description of the Subjects and Issues Involved: Pursuant to Public Act 98-651, this rulemaking makes changes in eligibility as required by federal law.
- 11) Are there any other proposed rulemakings pending on this Part? No
- 12) Statement of Statewide Policy Objective: This emergency rule neither creates nor expands any State mandate affecting units of local government.
- 13) Information and questions regarding this emergency rule shall be directed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENT

Springfield IL 62763-0002

217/782-1233

HFS.Rules@illinois.gov

The full text of the Emergency Amendment begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENT

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 123

COVERING ALL KIDS HEALTH INSURANCE PROGRAM

SUBPART A: GENERAL PROVISIONS

Section

123.100 General Description
123.110 Definitions

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section

123.200 Eligibility
EMERGENCY
123.210 Eligibility Exclusions and Terminations
123.220 Application Process
123.230 Determination of Financial Eligibility Using Modified Adjusted Gross Income (MAGI)
123.240 Eligibility Determination and Enrollment Process
123.250 Appeals
123.260 Annual Renewals
123.270 Adding Children to the Program and Changes in Participation
123.280 Insurance Information Exchange

SUBPART C: ALL KIDS PREMIUM LEVEL 2-8 HEALTH PLAN

Section

123.300 Covered Services
123.310 Service Exclusions
123.320 Co-payments and Cost Sharing
123.330 Premium Requirements
123.340 Non-payment of Premium
123.350 Provider Reimbursement

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AUTHORITY: The Covering ALL KIDS Health Insurance Program Act [215 ILCS 170] and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13].

SOURCE: Adopted by emergency rulemaking at 30 Ill. Reg. 10134, effective May 17, 2006, for a maximum of 150 days; adopted at 30 Ill. Reg. 16971, effective October 13, 2006; amended at 36 Ill. Reg. 1062, effective January 14, 2012; amended at 36 Ill. Reg. 12316, effective July 19, 2012; emergency amendment at 37 Ill. Reg. 15993, effective October 1, 2013, for a maximum of 150 days; amended at 38 Ill. Reg. 5989, effective February 26, 2014; emergency amendment at 38 Ill. Reg. 15666, effective July 7, 2014, for a maximum of 150 days.

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section 123.200 Eligibility**EMERGENCY**

A child may be eligible under the program provided that all of the following eligibility criteria are met:

- a) A child is not eligible for medical assistance under the Public Aid Code or benefits under the Children's Health Insurance Program Act;
- b) A child is under 19 years of age;
- c) A child is a resident of the State of Illinois; and
- d) The child meets the following conditions:
 - 1) Effective October 1, 2013 through June 30, 2014, Upon initial determination of eligibility the child is a member of a family whose countable income is at or below 300% of the Federal Poverty Level, as determined using MAGI methodology, except as provided in Section 123.270(a); and
 - A) The child has been without health insurance for at least 12 months prior to the date of application; ~~or~~
 - B) The child lost employer-sponsored health insurance when the child's parent's job ended; ~~or~~

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- C) The child has no health insurance and is less than one year old in the month of application for All Kids;~~or~~
 - D) The child has exhausted the life-time benefit limit of his or her health insurance;~~or~~
 - E) The child's health insurance is purchased under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA);~~or~~
 - F) The child was disenrolled for medical assistance under the Public Aid Code or benefits, including rebates, under the Children's Health Insurance Program Act within one year prior to applying under this Part; or
 - G) The child has health insurance provided by the child's noncustodial parent and the child's custodian is unable to access those health insurance benefits for the child.
- 2) Effective July 1, 2014, the child is a member of a family whose countable income is at or below 300% of the Federal Poverty Level, as determined using MAGI methodology, except as provided in Section 123.270(a); and in accordance with 42 CFR 457.805 (78 FR 42313, July 15, 2013) or any other federal requirement necessary to obtain federal financial participation for expenditures made under the Children's Health Insurance Program Act, at least one of the following applies:
- A) The child disenrolled from coverage under a group health plan at least 90 days prior to the first date of coverage under this Part 123;
 - B) The child is a newborn under age 1 whose responsible relative does not have affordable private or employer-sponsored insurance;
 - C) The child was disenrolled for medical assistance under the Public Aid Code or benefits, including rebates, under the Children's Health Insurance Program Act within one year prior to applying under this Part;

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- D) The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income;
 - E) The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a Qualified Health Plan through the Federally Facilitated Marketplace (Exchange) because the employer sponsored insurance in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v);
 - F) The cost of family coverage that includes the child exceeds 9.5 percent of the household income;
 - G) The employer who had been sponsoring the coverage in which the child was enrolled stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;
 - H) A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA);
 - I) The child has special health care needs; or
 - J) The child lost coverage due to the death or divorce of a parent.
- 32) Upon redetermination of eligibility:
- A) The child was initially enrolled under subsection (d)(1)(A) or (F);
or
 - B) Affordable health insurance is not available to the child. For the purpose of this Section, health insurance for the child is affordable when:the cost of the monthly premium for coverage of all children seeking coverage under this Part does not exceed 3% of the family's monthly countable income as determined under Section 123.230.

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- C) For the purposes of this subsection (d)(2), health insurance shall be considered unavailable to the child if subsection (d)(1)(D), (E) or (G) apply.
- D) Monthly countable income is at or below 300% of FPL as determined using the MAGI methodology. MAGI methodology will be used to determine eligibility effective April 1, 2014 pursuant to 42 CFR 457.315(b).

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 15666, effective July 7, 2014, for a maximum of 150 days).

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- 1) Heading of the Part: Medical Payment
- 2) Code Citation: 89 Ill. Adm. Code 140
- 3) Section Numbers: Emergency Action:
 140.420 Amendment
 140.442 Amendment
 140.Table D Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5]
- 5) Effective Date of Rule: July 7, 2014
- 6) If this emergency rule is to expire before the end of the 150-day period, please specify the date on which it is to expire: None
- 7) Date Filed with the Index Department: July 7, 2014
- 8) A copy of the emergency rule, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Reason for Emergency: PA 98-651 added 5 ILCS 100/5-45(r) which authorizes emergency rulemaking in order to implement its provisions. In PA 98-651, the General Assembly deemed that emergency rulemaking was necessary for the public interest, safety and welfare.
- 10) Complete Description of the Subjects and Issues Involved: Pursuant to PA 98-651, dental services for adults shall no longer be limited to emergencies effective July 1, 2014. Further, it exempts antipsychotics and treatment of certain children with complex medical needs from the prior approval four prescription limit policy.
- 11) Are there any other rulemakings pending on this Part? Yes

<u>Section Numbers</u> :	<u>Proposed Action</u> :	<u>Illinois Register Citation</u> :
140.12	Amendment	37 Ill. Reg. 19971; December 20, 2013
140.440	Amendment	37 Ill. Reg. 19971; December 20, 2013
140.80	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.82	Amendment	38 Ill. Reg. 14818; July 18, 2014

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140.84	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.86	New Section	38 Ill. Reg. 14818; July 18, 2014
140.420	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.421	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.425	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.442	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.457	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.458	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.472	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.485	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.488	Amendment	38 Ill. Reg. 14818; July 18, 2014
140.Table P	Repeal	38 Ill. Reg. 14818; July 18, 2014

12) Statement of Statewide Policy Objective: This emergency rule neither creates nor expands any State mandate affecting units of local government.

13) Information and questions regarding this rulemaking shall be directed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/782-1233

The full text of the Emergency Rule begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMSPART 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
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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 and VI and 12-13].

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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; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory 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 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

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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; 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.

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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 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

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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 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,

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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 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 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;

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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; peremptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; peremptory 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; peremptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days; emergency expired April 10, 2009; peremptory 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.

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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; amended at 37 Ill. Reg. 12855, effective July 24, 2013; emergency amendment at 37 Ill. Reg. 14196, effective August 20, 2013, for a maximum of 150 days; amended at 37 Ill. Reg. 17584, effective October 23, 2013; amended at 37 Ill. Reg. 18275, effective November 4, 2013; amended at 37 Ill. Reg. 20339, effective December 9, 2013; amended at 38 Ill. Reg. 859, effective December 23, 2013; emergency amendment at 38 Ill. Reg. 1174, effective January 1, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. 4330, effective January 29, 2014; amended at 38 Ill. Reg. 7156, effective March 13, 2014; amended at 38 Ill. Reg. 12141, effective May 30, 2014; emergency amendment at 38 Ill. Reg. 15673, effective July 7, 2014, for a maximum of 150 days

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.420 Dental Services**EMERGENCY**

- 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 services.

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- b) Effective July 1, 2012, except as specified in subsections (c) and (d), payment shall be made for covered dental services as described in subsections (b)(1) and (b)(2) and as listed in Table D:
- 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); and
 - 3) Performed by the dentist or under the direct supervision of the dentist.
- c) Payment shall not be made for experimental dental care and procedures performed only for cosmetic reasons.
- d) Effective for dates of service on or after July 1, 2012 through June 30, 2014, 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 by emergency rulemaking at 38 Ill. Reg. 15673, effective July 7, 2014, for a maximum of 150 days)

Section 140.442 Prior Approval of Prescriptions**EMERGENCY**

- 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 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

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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 the organizations (the panel is selected by the 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 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.
- 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

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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 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 the consulting organization.
 - 9) Effective July 1, 2012, the Department shall provide that the following types of drugs are available without prior approval:
 - A) Contraceptive drugs and products; and
 - B) 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 approval shall be given for drugs requiring 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

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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.
- c) Decisions on all requests for prior approval by telephone or other telecommunications device and, upon the Department's receipt of the 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.
- d) In accordance with subsection (d)(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 (d), 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.
 - 2) Brand name prescription drugs are exempt from the prior approval requirements of this subsection (d) if:

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- 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 (e), 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.
 - 4) Effective July 1, 2014, Antipsychotics.
- f) Effective July 1, 2014, the Department shall exempt, from the prior approval process required under subsection (e), children with complex medical needs enrolled in a care coordination entity contracted with the Department to solely coordinate care for such children, if the Department determines that the entity has a comprehensive drug reconciliation program.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 15673, effective July 7, 2014, for a maximum of 150 days)

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Section 140. TABLE D Schedule of Dental Procedures
EMERGENCYEffective July 1, ~~2014~~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.~~
 - 23) 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

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H) Panoramic film, one per 36 months

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

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- 2) Composite Restorations
 - A) Resin-based composite – 1 surface, anterior
 - 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

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- F) Sedative fillings
 - G) Pin retention – per tooth
 - 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

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- 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
 - 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 ~~ten~~five years based on age of prior placement age 21 and older every five years for ages 2-20)
- 1) Complete Dentures – including six months' post delivery care
 - A) Complete denture – maxillary
 - B) Complete denture – mandibular
 - C) Immediate denture – maxillary

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- 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~~
 - 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

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- E) Reline complete maxillary denture, laboratory
 - F) Reline complete mandibular denture, laboratory
 - G) Reline maxillary partial denture, laboratory
 - H) Reline mandibular partial denture, laboratory
- 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

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- O) Facial prosthesis, replacement
- P) Obturator prosthesis, surgical
- Q) Obturator prosthesis, definitive
- R) Obturator prosthesis, modification
- S) Mandibular resection, prosthesis with guide flange
- 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

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- HH) Fluoride gel carrier
 - II) Commissure splint
 - JJ) Surgical splint
 - KK) Unspecified maxillofacial prosthesis
- g) Fixed Prosthetic Services
- 1) Bridge Pontics
 - 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

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C) Root removal, exposed roots

~~2)~~ ~~Simple Extractions for Adults Age 21 and Older~~
~~Single tooth extraction~~

~~23)~~ Surgical Extractions

A) Surgical removal of erupted tooth

B) Removal of impacted tooth – soft tissues

C) Removal of impacted tooth – partially bony

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~~

~~35)~~ Other Surgical Procedures
Surgical exposure to aid eruption, ages 2-20 years

~~46)~~ Alveoloplasty

A) Alveoloplasty in conjunction with extractions, ages 2-20 years

B) Alveoloplasty not in conjunction with extractions, ages 2-20 years

~~57)~~ 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

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D) Removal of non-odontogenic cyst or tumor, over 1.25 cm

E) Incision and drainage of abscess

| 68) 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

| 79) Treatment of Fractures – Compound

A) Maxilla – open reduction

B) Maxilla – closed reduction

C) Mandible – open reduction

D) Mandible – closed reduction

| 810) Reduction of Dislocation

A) Open reduction of dislocation

B) Closed reduction of dislocation

| 911) 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

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- 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
 - 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) Professional Consultation
Consultation (narrative; diagnostic services provided by dentist other than practitioner providing treatment)
 - 4) Drugs
 - A) Therapeutic drug injection
 - B) Other drugs and medicaments
 - 5) Miscellaneous Services

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A) Unspecified procedures 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 by emergency rulemaking at 38 Ill. Reg. 15673, effective July 7, 2014, for a maximum of 150 days)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 1) Heading of the Part: Specialized Health Care Delivery Systems
- 2) Code Citation: 89 Ill. Adm. Code 146
- 3) Section Numbers: Emergency Action:
 146.225 Amendment
 146.650 Amendment
 146.900 New Section
 146.910 New Section
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date: July 7, 2014
- 6) If this emergency rule is to expire before the end of the 150-day period, please specify the date on which it is to expire: No
- 7) Date Filed with the Index Department: July 7, 2014
- 8) A copy of the emergency amendments, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Reason for Emergency: PA 98-104 and 98-651 add, respectively, 5 ILCS 100/5-45(q) and 5 ILCS 100/5-45(r). Each of these subsections authorizes emergency rulemaking as required for the public interest, safety, and welfare.
- 10) Complete Description of the Subject and Issues Involved: Pursuant to PA 98-651, this rulemaking de-links the rates for supportive living facilities from nursing facility rates and for facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013, makes reimbursement changes, and makes certain governance changes.
- 11) Are there any other rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
146.100	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.105	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.110	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.115	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.125	Amendment	38 Ill. Reg. 4628; February 21, 2014

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146.130	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.840	Amendment	38 Ill. Reg. 4628; February 21, 2014
146.550	Amendment	38 Ill. Reg. 6499; March 21, 2014

- 12) Statement of Statewide Policy Objective: This emergency rule neither creates nor expands any State mandate affecting units of local government.
- 13) Information and questions regarding this rulemaking shall be directed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/782-1233

The full text of the Emergency Rule begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER d: MEDICAL PROGRAMS

PART 146

SPECIALIZED HEALTH CARE DELIVERY SYSTEMS

SUBPART A: AMBULATORY SURGICAL TREATMENT CENTERS

Section

- 146.100 General Description
- 146.105 Definitions
- 146.110 Participation Requirements
- 146.115 Records and Data Reporting Requirements
- 146.125 Covered Ambulatory Surgical Treatment Center Services
- 146.130 Reimbursement for Services

SUBPART B: SUPPORTIVE LIVING FACILITIES

Section

- 146.200 General Description
- 146.205 Definitions
- 146.210 Structural Requirements
- 146.215 SLF Participation Requirements
- 146.220 Resident Participation Requirements
- 146.225 Reimbursement for Medicaid Residents

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- 146.230 Services
- 146.235 Staffing
- 146.240 Resident Contract
- 146.245 Assessment and Service Plan and Quarterly Evaluation
- 146.250 Resident Rights
- 146.255 Discharge
- 146.260 Grievance Procedure
- 146.265 Records and Reporting Requirements
- 146.270 Quality Assurance Plan
- 146.275 Monitoring
- 146.280 Non-Compliance Action
- 146.285 Voluntary Surrender of Certification

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146.290	Geographic Groups
146.295	Emergency Contingency Plan
146.300	Waivers
146.305	Reporting of Suspected Abuse, Neglect and Financial Exploitation
146.310	Facility Management of Resident Funds

SUBPART C: STATE HEMOPHILIA PROGRAM

Section	
146.400	Definitions
146.410	Patient Eligibility
146.420	Hemophilia Treatment Centers
146.430	Comprehensive Care Evaluation
146.440	Home Transfusion Arrangements
146.450	Obligations of the Department

SUBPART D: CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTERS

Section	
146.500	General Description
146.510	Definitions
146.520	Participation Requirements
146.530	Records and Data Reporting Requirements
146.540	Covered Children's Community-Based Health Care Center Services
146.550	Reimbursement for Services
146.560	Individuals Eligible for Services Provided in a Children's Community-Based Health Care Center
146.570	Prior and Post Approval of Services

SUBPART E: SUPPORTIVE LIVING FACILITIES WITH DEMENTIA CARE UNITS

Section	
146.600	General Description
146.610	Structural Requirements
146.620	Participation Requirements
146.630	Resident Participation Requirements
146.640	Services
146.650	Reimbursement for Medicaid Residents

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146.660	Staffing
146.670	Assessment and Service Plan and Quarterly Evaluation
146.680	Monitoring
140.690	Reporting Requirements
146.700	Resident Rights
146.710	Discharge

SUBPART F: BIRTH CENTERS

146.800	General Description
146.810	Participation Requirements
146.820	Record Requirements
146.830	Covered Birth Center Services
146.840	Reimbursement of Birth Center Services

SUBPART G: SPECIALIZED MENTAL HEALTH REHABILITATION FACILITIESSection146.900 General ProvisionsEMERGENCY146.910 ReimbursementEMERGENCY

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: Old Part repealed at 14 Ill. Reg. 13800, effective August 15, 1990; new Part adopted at 20 Ill. Reg. 4419, effective February 29, 1996; emergency amendment at 21 Ill. Reg. 13875, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 4430, effective February 27, 1998; emergency amendment at 22 Ill. Reg. 13146, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19914, effective October 30, 1998; amended at 23 Ill. Reg. 5819, effective April 30, 1999; emergency amendment at 23 Ill. Reg. 8256, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13663, effective November 1, 1999; amended at 24 Ill. Reg. 8353, effective June 1, 2000; emergency amendment at 26 Ill. Reg. 14882, effective October 1, 2002, for a maximum of 150 days; amended at 27 Ill. Reg. 2176, effective February 1, 2003; emergency amendment at 27 Ill. Reg. 10854, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18671, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 12218, effective August 11, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 14214, effective October 18, 2004, for a maximum

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of 150 days; amended at 29 Ill. Reg. 852, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2014, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 4360, effective March 7, 2005; expedited correction at 29 Ill. Reg. 14127, effective March 7, 2005; amended at 29 Ill. Reg. 6967, effective May 1, 2005; amended at 29 Ill. Reg. 14987, effective September 30, 2005; amended at 30 Ill. Reg. 8845, effective May 1, 2006; amended at 31 Ill. Reg. 5589, effective April 1, 2007; emergency amendment at 31 Ill. Reg. 5876, effective April 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11681, effective August 1, 2007; amended at 33 Ill. Reg. 11803, effective August 1, 2009; emergency amendment at 36 Ill. Reg. 6751, effective April 13, 2012, for a maximum of 150 days; amended at 36 Ill. Reg. 13885, effective August 27, 2012; amended at 37 Ill. Reg. 17624, effective October 28, 2013; expedited correction at 38 Ill. Reg. 4518, effective October 28, 2013; amended at 38 Ill. Reg. 13255, effective June 11, 2014; amended at 38 Ill. Reg. 13893, effective June 23, 2014; emergency amendment at 38 Ill. Reg. 15713, effective July 7, 2014, for a maximum of 150 days

SUBPART B: SUPPORTIVE LIVING FACILITIES

Section 146.225 Reimbursement for Medicaid Residents**EMERGENCY**

Supportive Living Programs (SLPs)SLFs shall accept the reimbursement provided in this Section as payment in full for all services provided to Medicaid residents.

- a) The Department shall establish its portion of the reimbursement for Medicaid residents by calculating 60 percent of the weighted average (weighted by Medicaid patient days) nursing facility rates for the geographic grouping as defined in Section 146.290. Each SLPSLF shall be paid 60 percent of the weighted average nursing facility geographic group rate, based upon the nursing facility geographic group in which it is located. The rates paid to SLPSLFs shall be updated semi-annually on April 1 and on October 1 to assure that the rates coincide with 60 percent of weighted average nursing facility geographic group rates. Notwithstanding the provisions of this subsection, the supportive living program facility rates shall remain at the level in effect on April 30, 2011.
 - 1) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 153.126, and subject to federal CMS approval, as of July 1, 2014, supportive living program rates shall no longer be 60 percent of the weighted average nursing facility rates for the geographic group rate, based upon the nursing facility geographic group in which it is located.

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NOTICE OF EMERGENCY AMENDMENTS

- 2) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 153.126, and subject to federal CMS approval, for dates of service on or after July 1, 2014, an increase of 8.85 percent to rates effective on June 30, 2014.
 - 3) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 153.126, and subject to federal CMS approval of the imposition of the assessment in 89 Ill. Adm. Code 140.86, for dates of service on or after July 1, 2014, an additional increase of 9.09 percent to rates effective July 1, 2014.
- b) The payment rate received by the SLPSLF from the Department for services, with the exception of meals, provided in accordance with Section 146.230 shall constitute the full and complete charge for services rendered. Additional payment, other than patient credits authorized by the Department, may not be accepted. Meals are included in the room and board amount paid by the resident.
- c) Single Occupancy: Each Medicaid resident of an SLPSLF shall be allotted a minimum of \$90 per month as a deduction from his or her income as a protected amount for personal use. The SLPSLF may charge each Medicaid resident no more than the current SSI rate for a single individual less a minimum of \$90 for room and board charges. Any income remaining after deduction of the protected minimum of \$90 and room and board charges shall be applied first towards medical expenses not covered under the Department's Medical Assistance Program. Any income remaining after that shall be applied to the charges for SLPSLF services paid by the Department.
- d) Double Occupancy: In the event a Medicaid eligible resident chooses to share an apartment, the Medicaid resident of an SLPSLF shall be allotted a minimum of \$90 per month as a deduction from his or her income as a protected amount for personal use. The SLPSLF may charge each Medicaid resident no more than the resident's share of the current SSI rate for a couple less a minimum of \$90 for room and board charges. The room and board rate for two Medicaid eligible individuals sharing an apartment cannot exceed the SSI rate for a married couple even if the two individuals sharing an apartment are unrelated. Any income of an individual remaining after deduction of the protected minimum of \$90 and room and board charges shall be applied first towards that individual's medical expenses not covered under the Department's Medical Assistance Program. Any income of an individual remaining after that shall be applied to that individual's charges for SLPSLF services paid by the Department. If one, or both, of the individuals sharing an apartment is not Medicaid eligible, the SLPSLF may negotiate its own

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NOTICE OF EMERGENCY AMENDMENTS

rate with the non-Medicaid individual or individuals.

- e) The room and board charge for Medicaid residents shall only be increased when the SSI amount is increased. Any room and board charge increase shall not exceed the amount of the SSI increase.
- f) Payment shall be made by the Department for up to 30 days per State fiscal year during a Medicaid resident's temporary absence from the SLPSLF when the absence is due to situations such as hospitalizations or vacations. The resident shall continue to be responsible for room and board charges during any absence. Involuntary discharge criteria relating to temporary absence are found at Section 146.255(b) and (d)(7). Nursing facilities that have a distinct part certified as an SLPSLF shall consider converted beds in the nursing facility's licensed capacity when calculating the 93 percent occupancy level for bed reserve payments pursuant to 89 Ill. Adm. Code 140.523.
 - 1) The day a resident is transferred to the hospital is the first day of the temporary absence.
 - 2) For all other temporary absences, except a long-term care admission, the day after resident leaves the SLPSLF is the first day of the temporary absence.
 - 3) The day before resident returns to the SLPSLF is the last day of the temporary absence.
 - 4) The Department does not pay for temporary absence due to admission to a long-term care facility. In this instance, an SLPSLF shall discharge the resident from the Department's database. An SLPSLF may choose to hold an apartment while a resident is in a long-term care facility.
 - 5) By agreement between the SLPSLF and a resident, an SLPSLF may continue to hold an apartment when a resident has exceeded the 30 days payable by the Department.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 15713, effective July 7, 2014, for a maximum of 150 days)

SUBPART E: SUPPORTIVE LIVING FACILITIES WITH DEMENTIA CARE UNITS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

Section 146.650 Reimbursement for Medicaid Residents**EMERGENCY**

The Department shall establish its portion of the reimbursement for Medicaid residents residing in the dementia care unit by calculating 72 percent of the weighted average (weighted by Medicaid patient days), for the geographic group in which the Supportive Living Program (SLP)~~SLF~~ is located (see Section 146.290), paid for Medicaid-eligible nursing facility residents residing in Department of Public Health certified Alzheimer's special care units pursuant to 77 Ill. Adm. Code 300.163.

- a) Notwithstanding the provisions set forth in Section 153.126, and subject to federal CMS approval, as of July 1, 2014, rates for the supportive living programs with residents residing in a dementia care unit, shall no longer be 72 percent of the weighted average nursing facility rates for the geographic group rate, based upon the nursing facility geographic group in which it is located.
- b) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 153.126, and subject to federal CMS approval, for dates of service on or after July 1, 2014, an increase of 8.85 percent to rates effective June 30, 2014.
- c) Notwithstanding the provisions set forth in Section 153.126, and subject to federal CMS approval of the imposition of the assessment in 89 Ill. Adm. Code 140.86, for dates of service on or after July 1, 2014, an additional increase of 9.09 percent to rates effective July 1, 2014.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 15713, effective July 7, 2014, for a maximum of 150 days)

SUBPART G: SPECIALIZED MENTAL HEALTH REHABILITATION FACILITIES**Section 146.900 General Provisions****EMERGENCY**

- a) The Specialized Mental Health Rehabilitation Act of 2013 provides for licensure of long-term care facilities that are federally designated as institutions for mental disease on the effective date of the Act and specialize in providing services to individuals with serious mental illness. On and after July 22, 2013, these facilities shall be governed by the Act and this Part instead of the Nursing Home Care Act.

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- b) All consent decrees that applied to facilities federally designated as institutions for mental disease prior to the enactment of the Specialized Mental Health Rehabilitation Act shall continue to apply to facilities licensed under the Specialized Mental Rehabilitation Act of 2013.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 15713, effective July 7, 2014, for a maximum of 150 days)

Section 146.910 Reimbursement**EMERGENCY**

- a) Facilities licensed under Specialized Mental Health Rehabilitation Act of 2013 shall be reimbursed at:
- 1) the rate in effect on June 30, 2014, less \$7.07 for each facility previously licensed under the Nursing Home Care Act on June 30, 2013; or
 - 2) the rate in effect on June 30, 2013 for each facility licensed under the Specialized Mental Health Rehabilitation Act on June 30, 2013.
- b) Any adjustment in the support component or the capital component for facilities licensed by the Department of Public Health under the Nursing Home Care Act shall apply equally to facilities licensed by the Department of Public Health under the Specialized Mental Health Rehabilitation Act of 2013.
- c) Notwithstanding the provisions set forth in Part 153, facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall receive a payment in the amount of \$29.43 per licensed bed, per day, for the period beginning June 1, 2014 and ending June 30, 2014.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 15713, effective July 7, 2014, for a maximum of 150 days)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENT

- 1) Heading of the Part: Reimbursement for Nursing Costs for Geriatric Facilities
- 2) Code Citation: 89 Ill. Adm. Code 147
- 3) Section Number: 147.310 Emergency Action: Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5]
- 5) Effective Date of Rule: July 7, 2014
- 6) If this emergency rule is to expire before the end of the 150-day period, please specify the date on which it is to expire: None
- 7) Date Filed with the Index Department: July 7, 2014
- 8) A copy of the emergency rule, including any materials incorporated by reference, is on file in the Agency's principal office and is available for public inspection.
- 9) Reason for Emergency: PA 98-651 added 5 ILCS 100/5-45(r), which authorizes emergency rulemaking in order to implement the provisions of PA 98-651. In PA 98-651, the General Assembly deemed that emergency rulemaking was necessary for the public interest, safety and welfare.
- 10) Complete Description of the Subjects and Issues Involved: Pursuant to PA 98-651, this rule makes certain rate changes for nursing facilities.
- 11) Are there any other proposed rulemakings pending on this Part? Yes

<u>Section Numbers</u> :	<u>Proposed Action</u> :	<u>Illinois Register Citation</u> :
147.310	Amendment	38 Ill. Reg. _____; July 18, 2014
147.335	Amendment	38 Ill. Reg. _____; July 18, 2014
- 12) Statement of Statewide Policy Objective: This emergency rule neither creates nor expands any State mandate affecting units of local government.
- 13) Information and questions regarding this emergency rule shall be directed to:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENT

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

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].

The full text of the Emergency Rule begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENT

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER d: MEDICAL PROGRAMS

PART 147

REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

Section

- 147.5 Minimum Data Set-Mental Health (MDS-MH) Based Reimbursement System (Repealed)
- 147.15 Comprehensive Resident Assessment (Repealed)
- 147.25 Functional Needs and Restorative Care (Repealed)
- 147.50 Service Needs (Repealed)
- 147.75 Definitions (Repealed)
- 147.100 Reconsiderations (Repealed)
- 147.105 Midnight Census Report
- 147.125 Nursing Facility Resident Assessment Instrument (Repealed)
- 147.150 Minimum Data Set (MDS) Based Reimbursement System (Repealed)
- 147.175 Minimum Data Set (MDS) Integrity (Repealed)
- 147.200 Minimum Data Set (MDS) On-Site Review Documentation (Repealed)
- 147.205 Reimbursement for Ventilator Dependent Residents (Repealed)
- 147.250 Costs Associated with the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) (Repealed)
- 147.300 Payment to Nursing Facilities Serving Persons with Mental Illness
- 147.301 Sanctions for Noncompliance
- 147.305 Psychiatric Rehabilitation Service Requirements for Individuals With Mental Illness in Residential Facilities (Repealed)
- 147.310 Implementation of a Case Mix System
- EMERGENCY
- 147.315 Nursing Facility Resident Assessment Instrument
- 147.320 Definitions
- 147.325 Resident Reimbursement Classifications and Requirements
- 147.330 Resource Utilization Groups (RUGs) Case Mix Requirements
- 147.335 Enhanced Care Rates
- 147.340 Minimum Date Set On-Site Reviews
- 147.345 Quality Incentives
- 147.346 Appeals of Nursing Rate Determination
- 147.350 Reimbursement for Additional Program Costs Associated with Providing

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Specialized Services for Individuals with Developmental Disabilities in Nursing
Facilities

147.355 Reimbursement for Residents with Exceptional Needs (Repealed)

- 147.TABLE A Staff Time (in Minutes) and Allocation by Need Level (Repealed)
- 147.TABLE B MDS-MH Staff Time (in Minutes and Allocation by Need Level) (Repealed)
- 147.TABLE C Comprehensive Resident Assessment (Repealed)
- 147.TABLE D Functional Needs and Restorative Care (Repealed)
- 147.TABLE E Service (Repealed)
- 147.TABLE F Social Services (Repealed)
- 147.TABLE G Therapy Services (Repealed)
- 147.TABLE H Determinations (Repealed)
- 147.TABLE I Activities (Repealed)
- 147.TABLE J Signatures (Repealed)
- 147.TABLE K Rehabilitation Services (Repealed)
- 147.TABLE L Personal Information (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, VI and 12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 140.900 thru 140.912 and 140.Table H and 140.Table I at 12 Ill. Reg. 6956; amended at 13 Ill. Reg. 559, effective January 1, 1989; amended at 13 Ill. Reg. 7043, effective April 24, 1989; emergency amendment at 13 Ill. Reg. 10999, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 16796, effective October 13, 1989; amended at 14 Ill. Reg. 210, effective December 21, 1989; emergency amendment at 14 Ill. Reg. 6915, effective April 19, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 9523, effective June 4, 1990, for a maximum of 150 days; emergency expired November 1, 1990; emergency amendment at 14 Ill. Reg. 14203, effective August 16, 1990, for a maximum of 150 days; emergency expired January 13, 1991; emergency amendment at 14 Ill. Reg. 15578, effective September 11, 1990, for a maximum of 150 days; emergency expired February 8, 1991; amended at 14 Ill. Reg. 16669, effective September 27, 1990; amended at 15 Ill. Reg. 2715, effective January 30, 1991; amended at 15 Ill. Reg. 3058, effective February 5, 1991; amended at 15 Ill. Reg. 6238, effective April 18, 1991; amended at 15 Ill. Reg. 7162, effective April 30, 1991; amended at 15 Ill. Reg. 9001, effective June 17, 1991; amended at 15 Ill. Reg. 13390, effective August 28, 1991; emergency amendment at 15 Ill. Reg. 16435, effective October 22, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 4035, effective March 4, 1992; amended at 16 Ill. Reg. 6479, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 13361, effective August 14,

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1992, for a maximum of 150 days; amended at 16 Ill. Reg. 14233, effective August 31, 1992; amended at 16 Ill. Reg. 17332, effective November 6, 1992; amended at 17 Ill. Reg. 1128, effective January 12, 1993; amended at 17 Ill. Reg. 8486, effective June 1, 1993; amended at 17 Ill. Reg. 13498, effective August 6, 1993; emergency amendment at 17 Ill. Reg. 15189, effective September 2, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 2405, effective January 25, 1994; amended at 18 Ill. Reg. 4271, effective March 4, 1994; amended at 19 Ill. Reg. 7944, effective June 5, 1995; amended at 20 Ill. Reg. 6953, effective May 6, 1996; amended at 21 Ill. Reg. 12203, effective August 22, 1997; amended at 26 Ill. Reg. 3093, effective February 15, 2002; emergency amendment at 27 Ill. Reg. 10863, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18680, effective November 26, 2003; expedited correction at 28 Ill. Reg. 4992, effective November 26, 2003; emergency amendment at 29 Ill. Reg. 10266, effective July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 18913, effective November 4, 2005; amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. 7409, effective September 11, 2006; amended at 31 Ill. Reg. 8654, effective June 11, 2007; emergency amendment at 32 Ill. Reg. 415, effective January 1, 2008, for a maximum of 150 days; emergency amendment suspended at 32 Ill. Reg. 3114, effective February 13, 2008; emergency suspension withdrawn in part at 32 Ill. Reg. 4399, effective February 26, 2008 and 32 Ill. Reg. 4402, effective March 11, 2008 and 32 Ill. Reg. 9765, effective June 17, 2008; amended at 32 Ill. Reg. 8614, effective May 29, 2008; amended at 33 Ill. Reg. 9337, effective July 1, 2009; emergency amendment at 33 Ill. Reg. 14350, effective October 1, 2009, for a maximum of 150 days; emergency amendment modified in response to the objection of the Joint Committee on Administrative Rules at 34 Ill. Reg. 1421, effective January 5, 2010, for the remainder of the 150 days; emergency expired February 27, 2010; amended at 34 Ill. Reg. 3786, effective March 14, 2010; amended at 35 Ill. Reg. 19514, effective December 1, 2011; amended at 36 Ill. Reg. 7077, effective April 27, 2012; emergency amendment at 38 Ill. Reg. 1205, effective January 1, 2014, for a maximum of 150 days; Sections 147.335(a)(7)(B) and 147.355(b) of the emergency amendment suspended by the Joint Committee on Administrative Rules at 38 Ill. Reg. 3385, effective January 14, 2014; suspension withdrawn at 38 Ill. Reg. 5898, effective March 7, 2014; emergency amendment modified in response to JCAR Objection at 38 Ill. Reg. 6707, effective March 7, 2014, for the remainder of the 150 days; amended at 38 Ill. Reg. 12173, effective May 30, 2014; emergency amendment at 38 Ill. Reg. 15723, effective July 7, 2014, for a maximum of 150 days.

Section 147.310 Implementation of a Case Mix System**EMERGENCY**

- a) P.A. 98-0104 requires the Department to implement, effective January 1, 2014, an evidence-based payment methodology for the reimbursement of nursing services.

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The methodology shall take into consideration the needs of individual residents, as assessed and reported by the most current version of the nursing facility Minimum Data Set (MDS), adopted and in use by the federal government.

- b) This Section establishes the method and criteria used to determine the resident reimbursement classification based upon the assessments of residents in nursing facilities. Resident reimbursement classification shall be established utilizing the 48-group, Resource Utilization Groups IV (RUG-IV) classification scheme and weights as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). An Illinois specific default group is established in subsection (f)(3) of this Section and identified as AA1 with an assigned weight equal to the weight assigned to group PA1.
- c) The pool of funds available for distribution by case mix shall be determined using the formula contained below. Base rate spending pool shall be:
 - 1) The base year resident days, which are calculated by multiplying the number of Medicaid residents in each nursing facility based on MDS comprehensive assessments for Medicaid residents on March 31, 2012, multiplied by 365 days.
 - 2) Each facility's nursing component per diem in effect on July 1, 2012 shall be multiplied by the number determined in subsection (c)(1) of this Section.
 - 3) Thirteen million is added to the result of subsection (c)(2) of this Section, to adjust for the exclusion of nursing facilities defined as Class I IMDs.
- d) For each nursing facility with Medicaid residents as indicated by the MDS data defined in subsection (c)(1) of this Section, weighted days adjusted for case mix and regional wage adjustment shall be calculated. For each nursing facility this calculation is the product of:
 - 1) Base year resident days as calculated in subsection (c)(1) of this Section.
 - 2) The nursing facility's regional wage adjustor based on the Health Service Areas (HSA) groupings and adjustors in effect on April 30, 2012.

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- 3) Facility weighted case mix which is the number of Medicaid residents as indicated by the MDS data defined in subsection (c)(1) of this Section multiplied by the associated case weight for the RUG-IV 48-group model using standard RUG-IV procedures for index maximization.
- 4) The sum of the products calculated for each nursing facility in subsections (d)(1) through (d)(3) of this Section shall be the base year case mix, rate adjusted weighted days.
- e) The statewide RUG-IV nursing base per diem rate effective on:
 - 1) January 1, 2014, shall be the quotient of subsection (c) of this Section divided by the sum calculated under subsection (d)(4) of this Section and is \$83.49.
 - 2) July 1, 2014, shall be the rate calculated in subsection (e)(1) of this Section increased by \$1.76.
- f) For services provided on or after:
 - 1) January 1, 2014, the Department shall compute and pay a facility-specific nursing component of the per diem rate as the arithmetic mean of the resident-specific nursing components, as determined in subsection (d) of this Section, assigned to Medicaid-enrolled residents on record, as of 30 days prior to the beginning of the rate period, in the Department's Medicaid Management Information System (MMIS), or any successor system, as present in the facility on the last day of the second quarter preceding the rate period. The RUG-IV nursing component per diem for a nursing facility shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index to be calculated quarterly, and the regional wage adjustor. Transition rates for services provided between January 1, 2014 and December 31, 2014, shall be as follows:
 - A) The transition RUG-IV per diem nursing rate for nursing facilities whose rate calculated in this subsection is greater than the nursing component rate in effect July 1, 2012, shall be paid the sum of:

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- i) The nursing component rate in effect July 1, 2012; plus
 - ii) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012, multiplied by 0.88.
 - B) The transition RUG-IV per diem nursing rate for nursing facilities whose rate calculated in this subsection is less than the nursing component rate in effect July 1, 2012, shall be paid the sum of:
 - i) The nursing component rate in effect July 1, 2012; plus
 - ii) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012, multiplied by 0.13.
- 2) Effective for dates of service on or after July 1, 2014 a per diem add-on to the RUGS methodology will be included as follows:
- A) \$0.63 for each resident that scores I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.
 - B) \$2.67 for each resident that scores "1" or "2" in any items S1200A through S1200I and also scores in the RUG groups PA1, PA2, BA1, and BA2.

~~Effective for dates of service on or after January 1, 2015, subject to the requirement of P.A. 98-0104 that the Department submit a rule by January 1, 2014, which establishes a reimbursement methodology that is reflective of the intensity of care and services requirements of the low need residents in the lowest RUG-IV groups, the Department will calculate quarterly the value of a per diem increase of \$1.00 multiplied by 365 divided by total facility resident days for each resident reporting in the low four RUG groups PA1, PA2, BA1 or BA2, as of September 30, 2013. The value of this increase will be applied to the per diem rate of each nursing facility in which total resident occupancy is at least 70 percent Medicaid on a quarterly basis.~~

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- 3) The Department shall determine the group to which a resident is assigned using the 48-group RUG-IV classification scheme with an index maximization approach. A resident for whom RUGs resident identification information is missing, or inaccurate, or for whom there is no current MDS record for that quarter, shall be assigned to default group AA1. A resident for whom an MDS assessment does not meet the federal CMS edit requirements as described in the Long Term Care Resident Assessment Instrument (RAI) Users Manual or for whom an MDS assessment has not been submitted within 14 calendar days after the time requirements in Section 147.315 shall be assigned to default group AA1.
 - 4) The assessment used for the purpose of rate calculation shall be identified as an Omnibus Budget Reconciliation Act (OBRA) assessment on the MDS following the guidance in the RAI Manual.
 - 5) The MDS used for the purpose of rate calculation shall be determined by the Assessment Reference Date (ARD) identified on the MDS assessment.
- g) The Department shall provide each nursing facility with information that identifies the group to which each resident has been assigned.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 15723, effective July 7, 2014, for a maximum of 150 days)

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- 1) Heading of the Part: Long Term Care Reimbursement Changes
- 2) Code Citation: 89 Ill. Adm. Code 153
- 3) Section Number: 153.126 Emergency Action: Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5]
- 5) Effective Date: July 7, 2014
- 6) If this emergency rule is to expire before the end of the 150-day period, please specify the date on which it is to expire: No
- 7) Date Filed with the Index Department: July 7, 2014
- 8) A copy of the emergency rule, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Reason for Emergency: PA 98-651 added 5 ILCS 100/5-45(r), which authorizes emergency rulemaking in order to implement the provisions of PA 98-651. PA 98-651 deemed that emergency rulemaking was necessary for the public interest, safety, and welfare.
- 10) Complete Description of the Subject and Issues Involved: Pursuant to PA 98-651, this rulemaking makes changes to the support component of the rates of certain nursing facilities and, with respect to long-term care facilities for persons under 22 years of age serving clinically complex residents, defines these facilities, places them on an expedited payment schedule, establishes per diem rates, and defines clinically complex persons under 22 years of age.
- 11) Are there any other rulemakings pending on this Part? No
- 12) Statement of Statewide Policy Objective: The emergency amendment neither creates nor expands any State mandate affecting units of local government.
- 13) Information and questions regarding this emergency rule shall be directed to:

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Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/782-1233
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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].

The full text of the Emergency Rule begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY 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

EMERGENCY

- 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

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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, 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; emergency amendment at 38 Ill. Reg. 15732, effective July 7, 2014, for a maximum of 150 days.

Section 153.126 Long Term Care Facility Medicaid Per Diem Adjustments**EMERGENCY**

- 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.

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- 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 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.
- h) Notwithstanding the provisions set forth in Sections 153.100, 153.125, and 89 Ill. Adm. Code 140.560 and 140.561, for services provided on or after July 1, 2014, the support component of a nursing facility's rate for facilities licensed under the

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Nursing Home Care Act as skilled or intermediate care facilities (SNF/ICF) shall be the rate in effect on June 30, 2014, increased by 8.17%.

- i) Long-term care facilities for persons under 22 years of age serving clinically complex residents.
 - 1) Effective for dates of service on or after July 1, 2013, long-term care facilities for persons under 22 years of age serving clinically complex residents, means facilities licensed by the Department of Public Health as a long-term care facilities for persons under 22 years of age that serve severely and chronically ill pediatric patients requiring:
 - A) exceptional care; and
 - B) have 30% or more of their patients receiving ventilator care.
 - 2) For dates of services starting July 1, 2013, long-term care facilities for persons under 22 years of age serving clinically complex residents shall receive Medicaid reimbursement on 30-day expedited schedule.
 - 3) Effective for dates of service on or after July 1, 2014, for purposes of this Section, a person under 22 years of age, is considered clinically complex if the person requires at least one of the following medical services:
 - A) Tracheostomy care with dependence on mechanical ventilation for a minimum of six hours each day.
 - B) Tracheostomy care requiring suctioning at least every six hours, room air mist or oxygen as needed, and dependence on one of the treatment procedures listed under subsection (D) excluding the procedure listed in subsection (D)(i) of this Section.
 - C) Total parenteral nutrition or other intravenous nutritional support and one of the treatment procedures listed under subsection (D) of this Section.
 - D) The following treatment procedures apply to the conditions in subsection (B) and (C) of this Section:

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- i) Intermittent suctioning at least every eight hours and room air mist or oxygen as needed.
 - ii) Continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent via a peripheral or central line, without continuous infusion.
- 4) Reimbursement.
- A) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 140, 144, and 147 and subject to federal approval of changes to the Title XIX State Plan, for dates of service starting July 1, 2014 through implementation of a new reimbursement system, long-term care facilities for persons under 22 years of age serving clinically complex residents, shall receive a per diem rate of \$304 for clinically complex residents.
 - B) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 140, 144, and 147 and subject to federal approval of changes to the Title XIX State Plan, for dates of service starting July 1, 2014, long-term care facilities for persons under 22 years of age serving clinically complex residents that have a policy documenting their method of routine assessment of a resident's potential for being weaned from a ventilator with interventions implemented noted in the resident's record, shall receive a per diem rate of \$669 for clinically complex residents on a ventilator.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 15732, effective July 7, 2014, for a maximum of 150 days)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENT

- 1) Heading of the Part: Pay Plan
- 2) Code Citation: 80 Ill. Adm. Code 310
- 3) Section Number: 310.APPENDIX A TABLE S Peremptory Action: Amendment
- 4) Reference to the Specific State or Federal Court Order, Federal Rule or Statute that Requires this Peremptory Rulemaking: The Department of Central Management Services (CMS) is amending Section 310.Appendix A Table S to reflect the Memorandum of Understanding (MOU) between CMS and the Laborers' International Union of North America – Illinois State Employees Association, Local 2002 and the Southern and Central Illinois Laborers' District Council for the Shift Supervisor title positions at the Department of Corrections Correctional Work Camps signed June 3, 2014. The MOU assigns the VR-704-22 pay grade to the Shift Supervisor title positions at the Department of Corrections Correctional Work Camps effective July 1, 2014. Current or new employees appointed to the Shift Supervisor title positions at the Department of Corrections Correctional Work Camps are assigned to the VR-704-22 pay grade. The facilities where the Shift Supervisor title positions are at the Department of Corrections Correctional Work Camps include the Southwestern Correctional Center, Green County, Hardin County, Dixon Springs, Pittsfield, Clayton, DuQuoin, Vandalia and Murphysboro.
- 5) Statutory Authority: Authorized by Sections 8, 8a and 9(7) of the Personnel Code [20 ILCS 415], Section 1-5(d) of the Illinois Administrative Procedure Act [5 ILCS 100] and Sections 4, 6, 15 and 21 of the Illinois Public Labor Relations Act [5 ILCS 315].
- 6) Effective Date of Rulemaking: July 2, 2014
- 7) A Complete Description of the Subjects and Issues Involved: In Section 310.Appendix A Table S and the title table, the Shift Supervisor title positions at the Department of Corrections Correctional Work Camps, its title code 40800, bargaining unit and pay grade are added. The pay grade VR-704-22 Pay Plan Codes Q and S are added to the rate tables for employees hired before or on March 31, 2013 effective July 1, 2014, December 31, 2014 and for employees hired on or after April 1, 2013 effective July 1, 2014.
- 8) Does this rulemaking contain an automatic repeal date? No

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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- 9) Date Filed with the Index Department: July 2, 2014
- 10) This and other Pay Plan rulemakings are available in the Division of Technical Services of the CMS Bureau of Personnel.
- 11) Is this in compliance with Section 5-50 of the Illinois Administrative Procedure Act?
Yes
- 12) Are there any other proposed rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
310.Appendix A Table X	Amendment	38 Ill. Reg. 8507; April 25, 2014
310.100	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table A	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table D	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table E	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table F	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.Appendix A Table X	Amendment	38 Ill. Reg. 9719; May 9, 2014
310.410	Amendment	38 Ill. Reg. 13489; July 7, 2014
310.Appendix A Table A	Amendment	38 Ill. Reg. 13489; July 7, 2014
310.Appendix A Table W	Amendment	38 Ill. Reg. 13489; July 7, 2014
310.Appendix A Table AE	Amendment	38 Ill. Reg. 13489; July 7, 2014

- 13) Statement of Statewide Policy Objective: The amendment to the Pay Plan affects only the employees subject to the Personnel Code and does not set out any guidelines that affect local or other jurisdictions in the State.
- 14) Information and questions regarding this peremptory rulemaking shall be directed to:

Mr. Jason Doggett
 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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENT

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The full text of the Peremptory Amendment begins on the next page:

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENT

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

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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 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,

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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, 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,

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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, 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

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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 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; preemptory 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; preemptory 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; preemptory 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; preemptory amendment at 27 Ill. Reg. 17433, effective November 7, 2003; amended at 27 Ill. Reg. 18560, effective December 1, 2003; preemptory 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; preemptory amendment at 28 Ill. Reg. 7323, effective May 10, 2004; amended at 28 Ill. Reg. 8842, effective June 11, 2004; preemptory amendment at 28 Ill. Reg. 9717, effective June 28, 2004; amended at 28 Ill. Reg. 12585, effective August 27, 2004; preemptory amendment at 28 Ill. Reg. 13011, effective September 8, 2004; preemptory amendment at 28 Ill. Reg. 13247, effective September 20, 2004; preemptory amendment at 28 Ill. Reg. 13656, effective September

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27, 2004; emergency amendment at 28 Ill. Reg. 14174, effective October 15, 2004, for a maximum of 150 days; emergency expired March 13, 2005; preemptory amendment at 28 Ill. Reg. 14689, effective October 22, 2004; preemptory amendment at 28 Ill. Reg. 15336, effective November 15, 2004; preemptory amendment at 28 Ill. Reg. 16513, effective December 9, 2004; preemptory amendment at 29 Ill. Reg. 726, effective December 15, 2004; amended at 29 Ill. Reg. 1166, effective January 7, 2005; preemptory amendment at 29 Ill. Reg. 1385, effective January 4, 2005; preemptory amendment at 29 Ill. Reg. 1559, effective January 11, 2005; preemptory amendment at 29 Ill. Reg. 2050, effective January 19, 2005; preemptory amendment at 29 Ill. Reg. 4125, effective February 23, 2005; amended at 29 Ill. Reg. 5375, effective April 4, 2005; preemptory amendment at 29 Ill. Reg. 6105, effective April 14, 2005; preemptory amendment at 29 Ill. Reg. 7217, effective May 6, 2005; preemptory amendment at 29 Ill. Reg. 7840, effective May 10, 2005; amended at 29 Ill. Reg. 8110, effective May 23, 2005; preemptory amendment at 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,

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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, 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

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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 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

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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; emergency amendment at 37 Ill. Reg. 11395, effective July 1, 2013, for a maximum of 150 days; preemptory amendment at 37 Ill. Reg. 11524, effective July 3, 2013; preemptory amendment at 37 Ill. Reg. 12588, effective July 19, 2013; preemptory amendment at 37 Ill. Reg. 13762, effective August 8, 2013; preemptory amendment at 37 Ill. Reg. 14219, effective August 23, 2013; amended at 37 Ill. Reg. 16925, effective October 8, 2013; preemptory amendment at 37 Ill. Reg. 17164, effective October 18, 2013; preemptory amendment at 37 Ill. Reg. 20410, effective December 6, 2013; preemptory amendment at 38 Ill. Reg. 2974, effective January 9, 2014; amended at 38 Ill. Reg. 5250, effective February 4, 2014; preemptory amendment at 38 Ill. Reg. 6725, effective March 6, 2014; emergency amendment at 38 Ill. Reg. 9080, effective April 11, 2014, for a maximum of 150 days; preemptory amendment at 38 Ill. Reg. 9136, effective April 11, 2014; amended at 38 Ill. Reg. 9207, effective April 21, 2014; preemptory amendment at 38 Ill. Reg. 13416, effective June 11, 2014; amended at 38 Ill. Reg. 14818, effective July 1, 2014; preemptory amendment at 38 Ill. Reg. 15739, effective July 2, 2014.

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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)	37015	VR-704	24

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and 8J (dietary manager function at Department of Corrections)			
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 at Department of Corrections Correctional Work Camps	40800	VR-704	22
Shift Supervisor – Hired before August 1, 2010 and on or after April 1, 2013 prior to December 31, 2014; all effective December 31, 2014	40800	VR-704	24
Shift Supervisor – Hired on or after August 1, 2010 through and including March 31, 2013 prior to December 31, 2014	40800	VR-704	23

NOTES: Shift Differential Pay – All Shift Supervisors shall conduct roll on scheduled work days and shall be compensated for 15 minutes for the roll call period at the appropriate rate. Unless specified below, Shift Supervisors shall receive ½ hour compensation for shift preparation at the appropriate rate. Those Shift Supervisors at facilities with 300 or more security staff shall receive 45 minutes preparation at the appropriate rate.

Option Clarification – 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.

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Longevity Pay – Effective July 1, 2010, the Step 8 rate shall be increased by \$50 per month for those employees who attain 10 years of continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010. For those employees who attain 15 years continuous service and have three or more years of creditable service on Step 8 in the same or higher pay grade on or before July 1, 2010, the Step 8 rate shall be increased by \$75 per month. Effective July 1, 2013, an employee on Step 8, having 10 years of continuous service and three years creditable service at Step 8, shall be paid \$75 per month. An employee with 15 years continuous service and three years of creditable service at Step 8 shall receive 15 years continuous service and three years of creditable service at Step 8 shall receive \$100 per month.

Shift Supervisor – Pay Grade VR-704-23 is not assigned to the Shift Supervisor title effective December 31, 2014.

Hired Before or On March 31, 2013**Effective July 1, 2014
Bargaining Unit: VR-704**

Pay Grade	Pay Plan Code	<u>STEPS</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>22</u>	<u>Q</u>	<u>5871</u>	<u>6058</u>	<u>6245</u>	<u>6573</u>	<u>6896</u>	<u>7219</u>	<u>7552</u>	<u>7870</u>
<u>22</u>	<u>S</u>	<u>5957</u>	<u>6146</u>	<u>6336</u>	<u>6656</u>	<u>6982</u>	<u>7304</u>	<u>7641</u>	<u>7960</u>
23	Q	6875	7241	7617	7984	8350	8728	9277	9647
23	S	6961	7321	7701	8066	8437	8815	9359	9734
24	B	6745	7103	7478	7834	8197	8566	9104	9467
24	Q	7051	7427	7812	8189	8564	8952	9515	9894
24	S	7139	7509	7898	8273	8653	9041	9599	9984

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25	B	7190	7583	7982	8380	8779	9178	9768	10159
25	Q	7510	7923	8337	8761	9177	9592	10208	10617
25	S	7599	8012	8426	8844	9262	9676	10295	10708
26	B	7671	8092	8522	8953	9370	9790	10424	10840
26	Q	8042	8479	8928	9378	9816	10255	10920	11356
27	B	8190	8635	9092	9552	9999	10448	11123	11568

Effective December 31, 2014
Bargaining Unit: VR-704

<u>Pay Grade</u>	<u>Pay Plan Code</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>	<u>8</u>
<u>22</u>	<u>Q</u>	<u>5871</u>	<u>6058</u>	<u>6245</u>	<u>6573</u>	<u>6896</u>	<u>7219</u>	<u>7552</u>	<u>7870</u>
<u>22</u>	<u>S</u>	<u>5957</u>	<u>6146</u>	<u>6336</u>	<u>6656</u>	<u>6982</u>	<u>7304</u>	<u>7641</u>	<u>7960</u>
24	B	6745	7103	7478	7834	8197	8566	9104	9467
24	Q	7051	7427	7812	8189	8564	8952	9515	9894
24	S	7139	7509	7898	8273	8653	9041	9599	9984
25	B	7190	7583	7982	8380	8779	9178	9768	10159
25	Q	7510	7923	8337	8761	9177	9592	10208	10617
25	S	7599	8012	8426	8844	9262	9676	10295	10708
26	B	7671	8092	8522	8953	9370	9790	10424	10840
26	Q	8042	8479	8928	9378	9816	10255	10920	11356
27	B	8190	8635	9092	9552	9999	10448	11123	11568

Hired On or After April 1, 2013

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Effective July 1, 2014
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>22</u>	<u>Q</u>	<u>5871</u>	<u>6058</u>	<u>6245</u>	<u>6573</u>	<u>6896</u>	<u>7219</u>	<u>7552</u>	<u>7870</u>
<u>22</u>	<u>S</u>	<u>5957</u>	<u>6146</u>	<u>6336</u>	<u>6656</u>	<u>6982</u>	<u>7304</u>	<u>7641</u>	<u>7960</u>
24	B	6408	6748	7104	7442	7787	8266	8922	9467
24	Q	6698	7056	7421	7780	8136	8639	9325	9894
24	S	6782	7134	7503	7859	8220	8725	9407	9984
25	B	6831	7204	7583	7961	8340	8857	9573	10159
25	Q	7135	7527	7920	8323	8718	9256	10004	10617
25	S	7219	7611	8005	8402	8799	9337	10089	10708
26	B	7287	7687	8096	8505	8902	9447	10216	10840
26	Q	7640	8055	8482	8909	9325	9896	10702	11356
27	B	7781	8203	8637	9074	9499	10082	10901	11568

(Source: Added by peremptory rulemaking at 38 Ill. Reg. 15739, effective July 2, 2014)

ILLINOIS DEPARTMENT OF AGRICULTURE

JULY 2014 REGULATORY AGENDA

- a) Part(s) (Heading and Code Citations): Farmland Preservation Act, (8 Ill. Adm. Code 700)
- 1) Rulemaking:
- A) Description: The Farmland Preservation Act requires that state agency policy statements and working agreements on farmland preservation shall be updated by the state agency and reviewed and approved by the Department of Agriculture every three years. The purpose of the rulemaking activity is to update the policy statements and working agreements, as necessary, to protect Illinois' agricultural land base from unnecessary state agency farmland conversion impacts.
- B) Statutory Authority: Farmland Preservation Act [505 ILCS 75/1]
- C) Scheduled meeting/hearing dates: Written comments may be submitted during the 45-day public comment period following publication of the proposed rule in the *Illinois Register*. A public hearing will be held near the end of the public comment period.
- D) Date agency anticipates First Notice: July 2014
- E) Effect on small businesses, small municipalities or not for profit corporations: None anticipated
- F) Agency contact person for information:
- Steve Chard
Illinois Department of Agriculture
P.O. Box 19281
Springfield IL 62794-9281
steve.chard@illinois.gov
- 217/785-2661
FAX: 217/557-0993
- G) Related rulemaking and other pertinent information: None

ILLINOIS DEPARTMENT OF AGRICULTURE

JULY 2014 REGULATORY AGENDA

b) Part(s) (Heading and Code Citations): Sustainable Agriculture, (8 Ill. Adm. Code 750)

1) Rulemaking:

A) Description: The intent of the Sustainable Agriculture Act to provide funding for the developmental research program that serves production agriculture in Illinois. The purpose of this rulemaking is to update Section 750.40 Guidelines for Research, Demonstration and Education Projects.

B) Statutory Authority: Sustainable Agriculture Act [505 ILCS 135/1-5]

C) Scheduled meeting/hearing dates: Written comments may be submitted during the 45-day public comment period following publication of the proposed rule in the *Illinois Register*. A public hearing will be held near the end of the public comment period.

D) Date agency anticipates First Notice: August 2014

E) Effect on small businesses, small municipalities or not for profit corporations: None anticipated

F) Agency contact person for information:

Mike Rahe
Illinois Department of Agriculture
P.O. Box 19281
Springfield IL 62794-9281
mike.rahe@illinois.gov

217/785-5594
FAX: 217/557-0993

G) Related rulemakings and other pertinent information: None

c) Part(s) (Heading and Code Citations): Groundwater Use Guidelines, (8 Ill. Adm. Code 675)

1) Rulemaking:

ILLINOIS DEPARTMENT OF AGRICULTURE

JULY 2014 REGULATORY AGENDA

- A) Description: The intent of the Water Use Act is for Illinois' citizens to effectively manage and conserve groundwater, to restrict withdrawals of groundwater in emergencies and to mitigate groundwater shortage conflicts. The purpose of this rulemaking is to update all sections of the administrative rules for the Act.
- B) Statutory Authority: Water Use Act [525 ILCS 45/1]
- C) Scheduled meeting/hearing dates: Written comments may be submitted during the 45-day public comment period following publication of the proposed rule in the *Illinois Register*. A public hearing will be held near the end of the public comment period.
- E) Date agency anticipates First Notice: August 2014
- F) Effect on small businesses, small municipalities or not for profit corporations: None anticipated
- G) Agency contact person for information:

Steve Chard
Illinois Department of Agriculture
P.O. Box 19281
Springfield IL 62794-9281
steve.chard@illinois.gov

217/785-2661
FAX: 217/557-0993

- H) Related rulemakings and other pertinent information: None
- d) Part(s) (Heading and Code Citations): General Operations of the State Fairs and Fairgrounds, (8 Ill. Adm. Code 270)
- 1) Rulemaking:

ILLINOIS DEPARTMENT OF AGRICULTURE

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- A) Description: This rulemaking assists in the efficient running of the Illinois State Fair by establishing clear standards for applying, reapplying, and paying for space rentals. This rulemaking also establishes operational hours for buildings and concessionaires and addresses guidelines for percentage rental contracts.
- B) Statutory Authority: State Fair Act [20 ILCS 210]
- C) Scheduled meeting/hearing dates: Written comments may be submitted during the 45-day public comment period following publication of the proposed rule in the *Illinois Register*.
- D) Date agency anticipates First Notice: July 2014
- E) Effect on small businesses, small municipalities or not for profit corporations: None
- F) Agency contact person for information:
- Amy Bliefnick
Illinois State Fair
P. O. Box 19281
Springfield IL 62794-9281
- 217/782-0770
FAX: 217/782-9115
- G) Related rulemakings and other pertinent information: None

ILLINOIS LIQUOR CONTROL COMMISSION

JULY 2014 REGULATORY AGENDA

a) Part(s) (Heading and Code Citations): Public Information, Rulemaking, and Organization, (2 Ill Adm. Code 2075)

1) Rulemaking:

A) Description: The proposed rules will clarify the intention of the legislature behind the "Three-Tier" system that retailers must purchase alcoholic liquor from licensed distributors only. Retailers may not purchase alcoholic liquors from other retailers or manufacturers unless exempt. Retailers also may not sell alcoholic liquor for future or subsequent resale.

Per the Open Meetings Act and the proposed rules, Commissioners may attend meetings through audio or video teleconferencing under certain conditions noted in the rule. Furthermore, the proposed rules will permit public attendance and comment at Commission meetings.

The proposed rules will remove the ambiguity of the Illinois Liquor Control Act's license eligibility statute by stating that the owners/officers/members of a revoked corporation, limited liability company, etc., are considered revoked persons in the same capacity as the revoked business entity.

The proposed rules allow the Commission to delegate to the administrative staff of the Commission the authority to act on its behalf by an official act.

The proposed rules define "alcoholic liquor" and the scope of the Illinois Liquor Control Act as it pertains to products and persons.

The proposed rules remove the requirement for multi-use facilities to invoice and store their alcoholic liquor separately within one central location by State liquor license number for investigative purposes.

The proposed rules clarify the requirements for hotels/motels to be permitted to sell alcohol via mini bars and room service.

The proposed rules delineate the jurisdictions of state and local regulative bodies as they pertain to boat licenses and establish requirements of boat liquor license holders.

ILLINOIS LIQUOR CONTROL COMMISSION

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The proposed rules define an "auction liquor license" and delineate the privileges it grants.

The proposed rules list the conditions that must be met before an in-state and out-of-state maker of wine can be permitted to sell its own manufactured wine direct to retail license holders.

The proposed rules list the conditions that must be met before an in-state and out-of-state maker of beer can be permitted to sell its own manufactured wine direct to retail license holders.

The proposed rules prohibit the importation of alcoholic liquor into Illinois for a non-personal or commercial use without first obtaining a license to import issued by the Commission, and these proposed rules list the conditions under which this may be permitted.

The proposed rules will outline guidelines to regulate product tastings, samplings, and test marketing with regards to serving amounts, entrance fees, tracking, extraneous materials, licenses, and general operation.

- B) Statutory Authority: Section 3-12(a)(2) of the Liquor Control Act [235 ILCS 5/3-12(a)(2)]
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date agency anticipates First Notice: We anticipate filing sometime in the next three months.
- E) Effect on small businesses, small municipalities or not for profit corporations: This rulemaking will affect holders of retail liquor licenses.
- F) Agency contact person for information:

Richard Haymaker
Chief Legal Counsel
Liquor Control Commission

ILLINOIS LIQUOR CONTROL COMMISSION

JULY 2014 REGULATORY AGENDA

100 W. Randolph, Suite 7-801
Chicago IL 60601

312/814-1804

G) Related rulemakings and other pertinent information: None

ILLINOIS RACING BOARD

JULY 2014 REGULATORY AGENDA

a) Part(s) (Heading and Code Citation): Medication, 11 Ill. Adm. Code 603

1) Rulemaking:

- A) Description: Part 603 may periodically need updating because the Board actively addresses threshold levels of therapeutic drugs and other medication issues. Technical changes may also be made.
- B) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]
- C) Scheduled meeting/hearing dates: Interested persons may send specific criticisms, suggestions, and/or comments to the Illinois Racing Board in writing during the First Notice Period.
- D) Date agency anticipates First Notice: Undetermined
- E) Effect on small businesses, small municipalities or not for profit corporations: None
- F) Agency contact person for information:
- Mickey Ezzo
Illinois Racing Board
100 W. Randolph Street
Suite 5-700
Chicago IL 60601
- 312/814-5017
Fax: 312/814-5062
mickey.ezzo@illinois.gov
- G) Related rulemakings and other pertinent information: None

b) Part(s) (Heading and Code Citation): Horse Health, 11 Ill. Adm. Code 605

1) Rulemaking:

ILLINOIS RACING BOARD

JULY 2014 REGULATORY AGENDA

- A) Description: Sections 1312.310 and 1413.250 may be repealed and "Medical Reasons for Ineligibility" may be updated and moved to Horse Health, Part 605.
- B) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]
- C) Scheduled meeting/hearing dates: Interested persons may send specific criticisms, suggestions, and/or comments to the Illinois Racing Board in writing during the First Notice Period.
- D) Date agency anticipates First Notice: Undetermined
- E) Effect on small businesses, small municipalities or not for profit corporations: None
- F) Agency contact person for information:

Mickey Ezzo
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Suite 5-700
Chicago IL 60601

312/814-5017
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mickey.ezzo@illinois.gov

- G) Related rulemakings and other pertinent information: None

c) Part(s) (Heading and Code Citation): Claiming Races, 11 Ill. Adm. Code 510

1) Rulemaking:

- A) Description: Sections 510.220 and 510.250 may be amended to be consistent and to conform the rule with current practice.

ILLINOIS RACING BOARD

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- B) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]
- C) Scheduled meeting/hearing dates: Interested persons may send specific criticisms, suggestions, and/or comments to the Illinois Racing Board in writing during the First Notice Period.
- D) Date agency anticipates First Notice: Undetermined
- E) Effect on small businesses, small municipalities or not for profit corporations: None
- F) Agency contact person for information:

Mickey Ezzo
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Chicago IL 60601

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Fax: 312/814-5062
mickey.ezzo@illinois.gov

- G) Related rulemakings and other pertinent information: None

d) Part(s) (Heading and Code Citation): Licensing, 11 Ill. Adm. Code 502

1) Rulemaking:

- A) Description: Subchapter H may be amended to include additional licensees.
- B) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]

ILLINOIS RACING BOARD

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- C) Scheduled meeting/hearing dates: Interested persons may send specific criticisms, suggestions, and/or comments to the Illinois Racing Board in writing during the First Notice Period.
- D) Date agency anticipates First Notice: Undetermined
- E) Effect on small businesses, small municipalities or not for profit corporations: None
- F) Agency contact person for information:
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mickey.ezzo@illinois.gov
- G) Related rulemakings and other pertinent information: None
- e) Part(s) (Heading and Code Citation): Hearings and Enforcement Proceedings, 11 Ill. Adm. Code 204
- 1) Rulemaking:
- A) Description: Section 204.60 will be amended to comply with House Bill 4235. This legislation allows an attorney licensed in another state, territory, or commonwealth of the U.S., the District of Columbia, or a foreign country, to appear before the Board as provided in Illinois Supreme Court 707. Section 204.20 will be amended to clarify that for an appeal of a disqualification of a horse in a race due to interference or claim of foul, the request for a hearing shall be filed no later than five business days after the date of the race in which a horse was disqualified.

ILLINOIS RACING BOARD

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- B) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]
- C) Scheduled meeting/hearing dates: Interested persons may send specific criticisms, suggestions, and/or comments to the Illinois Racing Board in writing during the First Notice Period.
- D) Date agency anticipates First Notice: Undetermined
- E) Effect on small businesses, small municipalities or not for profit corporations: None
- F) Agency contact person for information:
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Chicago IL 60601
- 312/814-5017
Fax: 312/814-5062
mickey.ezzo@illinois.gov
- G) Related rulemakings and other pertinent information: None

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

a) Part(s) (Heading and Code Citations): Income Tax, 86 Ill. Adm. Code 100

1) Rulemaking:

- A) Description: New rules will be added to Part 100 concerning the tax credit for Tech Prep Youth Vocational Programs (IITA Section 209); the reallocation of items under IITA Section 404; pass-through of investment credits from partnerships and Subchapter S corporations to their partners and shareholders; filing of refund claims and other collection matters, statutes of limitations, and interest computations.

Part 100 will be amended by adding rules and amending existing rules governing the computation of base income under Article 2 of the IITA, the allocation and apportionment of base income under Article 3 of the IITA, and the filing of returns and payment of taxes under Articles 5 and 6 of the IITA.

Part 100 will be amended to update the provisions defining unitary business groups and computing the combined tax liability of unitary business groups.

Part 100 will be amended by adding rules providing guidance on the addition and subtraction modifications allowed in IITA Section 203, on the credit for residential property taxes paid in IITA Section 208, on the acceptance of substitute W-2s, and rounding amounts on returns to the nearest dollar.

Part 100 will be amended to clarify definitions of terms in IITA Section 1501(a).

Part 100 will be amended to implement legislation enacted in 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013 and 2014, including the angel investment, historic preservation, small business jobs and hospital credits, the computation of the credit for taxes paid to other states, the credits and subtractions allowed with respect to enterprise zones, the allowance of Economic Development for a Growing Economy credits to be used against withholding obligations, credits for hiring veterans and ex-felons, bonus depreciation adjustments, withholding by employers, partnerships,

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Subchapter S corporations and trusts, changes to apportionment formulas and taxation of real estate investment trusts and their investors, tax-exempt bonds, recoveries of itemized deductions, repayments of claim-of-right amounts, special net loss rules for cooperatives and real estate mortgage investment companies, the computation of tax for partners in civil unions, the surcharge on registrants under the Compassionate Use of Medical Cannabis Pilot Program, and appeals to the Tax Tribunal.

Part 100 will be amended to provide additional guidance on nexus and on the Illinois income tax consequences of changes in federal income tax laws.

Part 100 will be amended to reflect amendments to the IITA in 2013 regarding composite returns and pass-through entity withholding.

Finally, the Department will continue the updating and correction of Part 100.

- B) Statutory Authority: 35 ILCS 5/101 and 35 ILCS 5/1401
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: As noted above, there will be a number of rulemakings proposed with respect to Part 100 over the next six months. We anticipate filing rulemakings amending Part 100 on a regular basis during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: These rulemakings will affect any business that incurs an income tax filing obligation.
- F) Agency contact person for information:

Paul Caselton
Deputy General Counsel, Income Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

Springfield IL 62794

217/524-3951

G) Related rulemakings and other pertinent information: None

b) Part(s) (Heading and Code Citations): Property Tax Code, 86 Ill. Adm. Code 110

1) Rulemaking:

A) Description: Part 110 will be amended to implement the new Disabled Persons' Homestead Exemption under 35 ILCS 200/15-168.

Part 110 will be amended to adopt new rules to implement changes made to the Senior Citizens Assessment Freeze Homestead Exemption under 35 ILCS 200/15-172.

Part 110 will be amended with respect to 110.162 for Township and Multi-Township Assessor Qualifications. The amendment deals with the approved designation list from the Department of Revenue.

Part 110 will be amended with respect to 110.155 to update population changes in counties, which resulted in different requirements for those counties with respect to course and examination requirements for board of review members. The changes in the county populations will be reflected in the attached map accompanying Part 110.155, referred to as Illustration A. Part 110.155 will also be amended to correct typographical errors in subsections b) 3); b) 5); d); and e) 3).

Part 110 may be amended to reflect the provisions of Public Act 97-0688, which made changes to property tax exemption law concerning hospitals.

B) Statutory Authority: Implementing the Property Tax Code [35 ILCS 200] and authorized by Section 2505-625 of the Civil Administrative Code of Illinois [20 ILCS 2505/2505-625]; 35 ILCS 200/15-168; 35 ILCS 200/15-65; 35 ILCS 200/15-172; 35 ILCS 200/6; 35 ILCS 200/6-10; and 35 ILCS 200/6-32

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- C) Scheduled meeting/hearing dates: No schedule has been established.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings amending Part 110 during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: None
- F) Agency contact person for information:
- Robin W. Gill
Associate Counsel, Property Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/524-4886
- G) Related rulemakings and other pertinent information: None
- c) Part(s) (Heading and Code Citations): Rental Housing Support Program, 86 Ill. Adm. Code 121
- 1) Rulemaking:
- A) Description: A new Part will be promulgated to implement the new Rental Housing Support Program.
- B) Statutory Authority: 55 ILCS 5/3-5018
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings creating Part 121 during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: De minimis. Small business and not for profit organizations

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are subject to the \$10 recording fee for real estate related documents. Units of local government are exempt under the statute.

F) Agency contact person for information:

Robin W. Gill
Associate Counsel, Property Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/524-4886

G) Related rulemakings and other pertinent information: Noned) Part(s) (Heading and Code Citations): Retailers' Occupation Tax, 86 Ill. Adm. Code 1301) Rulemaking:A) Description: Amendments will be made to update the Retailers' Occupation Tax regulations to reflect new statutory developments, decisional law and Department policies. Rulemakings are also promulgated as part of the Department's continuing effort to codify policies contained in various letter rulings. Some of the highlights of these changes include:

Amendment of Section 130.415 (Transportation and Delivery Charges) and 130.410 (Cost of Doing Business Not Deductible), to provide clarity on the taxation of shipping and delivery charges, and to clarify what tax rate applies to taxable transportation and delivery charges for an order that contains both high tax rate and low tax rate items.

Addition of a new regulation that implements the provisions of PA 98-628 and [anticipated] HB 5684, which change the method of determining the "selling price" for first division and certain types of second division motor vehicles that are leased for defined periods in excess of one year.

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Amendment or repeal of various Retailers' Occupation Tax regulations that are inconsistent with the Department's anticipated local tax sourcing regulations (e.g., Section 130.601, 130.605 and 130.610).

Amendment of Section 130.2007 to explain the proper use by an exempt organization of its exemption identification number issued by the Department and consequences of an organization's failure to use ordinary care to ensure that the exemption identification number is not improperly utilized. Consequences include revocation of the exemption identification number.

Creation of a new section to provide guidance regarding the documentation requirements for sales by retailers to exempt organizations holding active exemption numbers issued by the Department.

Amendment of Section 130.450 regarding installation, alteration, and special service charges to provide further guidance through examples for retailers who sell items that are commonly installed into real estate, such as cabinets and counter tops.

Amendment of Section 130.340 regarding rolling stock to provide guidance through examples of items that qualify for the exemption but do not become a part of the vehicle and to clarify the types of registration numbers carriers need to provide to document that they are for hire carrier; amendments are also anticipated in response to P. A. 98-584 (new test for aircraft and watercraft used as rolling stock).

Amendment of Section 130.605 to add examples regarding the drive-away permit exemption described in subsection (b) of that Section and to provide additional guidance regarding the scope of the reciprocal drive-away exemption, and to change the period of use from "30 or more days" to "more than 30 days" that will trigger Use Tax liability for a vehicle that was purchased in this State under the drive-away permit exemption. This last change is being proposed to conform to the recent change by the Secretary of State's Office to extend the time period for a drive-away permit for a vehicle for a maximum of 30 days.

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New section to describe how "deal of the day" types of transactions are taxed and to provide examples regarding those transactions.

Amendment of Sections 130.330, 130.101, and 130.1951 to reflect the changes made as a result of the enactment of PA 98-0583 (sales of electricity are not subject to tax; manufacturing machinery and equipment exemption does not apply to equipment used to produce electricity; expanded manufacturing machinery and equipment exemption does not apply to tangible personal property used in the production of electricity).

Amendment of Sections 130.1951, 130.1952 and 130.1954 to reflect the provisions of PA 97-905, including reporting requirements for businesses receiving enterprise zone/high impact business/river edge incentives and new procedures for use in documenting the building materials exemption for these incentives. Additional changes are made in response to PA 98-109, which provides additional requirements for contractor reporting and authorizes rules for failure to properly report.

Amendment of Sections 130.501 and 130.745 to reflect changes made as a result of PA 98-0496, which authorizes the Department to disallow the vendor's discount under certain circumstances

Amendment of Section 130.910 in response to enactment of PA 98-0352, which prohibits the sale, possession and use of automated sales suppression devices, or zappers.

Amendment of Section 130.910 in response to enactment of PA 97-1074, which added the criminal offense of sales tax evasion.

- B) Statutory Authority: 35 ILCS 120/12
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: As noted above, there will be a number of rulemakings proposed with respect to Part 130 over the next six months. We anticipate filing rulemakings amending Part 130 on a regular basis during the next six months of this year.

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- E) Effect on small business, small municipalities or not for profit corporations: Small businesses that sell tangible personal property at retail will be affected by these regulations. Businesses that sell tangible personal property and have that property delivered to their customers, including sales made through the use of the Internet, mail order, telephone and television orders, will be impacted by the changes to Sections 130.410 and 130.415 regarding transportation and delivery charges. Retailers who sell counter tops and cabinets will be impacted by the changes to Section 130.450. Tax exempt organizations will be affected by the changes proposed to Section 130.2005, 130.2007, and the new section providing guidance on how to document exempt sales to those organizations. Persons purchasing aircraft and watercraft for use as rolling stock moving in interstate commerce will be affected by the changes to Section 130.340, as will sellers of such items.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/782-2844
- G) Related rulemakings and other pertinent information: None
- e) Part(s) (Heading and Code Citations): Service Occupation Tax, 86 Ill. Adm. Code 140
- 1) Rulemaking:
- A) Description: Amendments will be made as part of a general update to clarify application of the Service Occupation Tax and to reflect recent decisional law, statutory changes and Department policy. Some of the highlights of these changes are the addition of language prohibiting the sale, possession and use of automated sales suppression devices, or zappers in response to PA 98-352

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- B) Statutory Authority: 35 ILCS 115/12
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: As noted above, there will be a number of rulemakings proposed with respect to Part 140 over the next six months. We anticipate filing rulemakings amending Part 140 on a regular basis during the next six months of this year.
- E) Effect on small business, small municipalities or not-for-profit corporations: Servicemen transferring tangible personal property incident to service will be affected by these rules.
- F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/782-2844

- G) Related rulemakings and other pertinent information: None

f) Part(s) (Heading and Code Citations): Use Tax, 86 Ill. Adm. Code 150

1) Rulemaking:

- A) Description: Amendments will be made to update the Use Tax regulations to reflect new statutory developments, decisional law and Department policies. Some of the highlights of these changes include:

Amendment of Section 150.310 to change the period of use from "30 or more days" to "more than 30 days" that will trigger Use Tax liability for a vehicle that was purchased in this State under the drive-away permit

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exemption. The change to Section 150.310 is being made in order to conform to the recent change by the Secretary of State's Office to extend the time period for a drive-away permit for a maximum of 30 days.

Amendment of Section 150.401 to clarify when out-of-State retailers attending trade shows in this State are not considered to have a Use Tax collection on remote sales to Illinois customers and to provide guidance on other issues presented by retailer presence at trade shows in Illinois.

Add a new Section 150.1015 in response to PA 98-0352, which prohibits the sale, possession and use of automated sales suppression devices, or zappers, and amend Part 150, Subpart I, dealing with penalties and interest.

Amend the definition of "retailer maintaining a place of business in this State" in Section 150.201 to include the provisions of anticipated enactment of SB 352, which amended the "click-through" nexus provisions of this definition in response to Performance Marketing Ass'n v. Hamer, 2013 IL 114496.

- B) Statutory Authority: 35 ILCS 105/12
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings amending Part 150 during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: These amendments will affect persons subject to the Use Tax.
- F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500

DEPARTMENT OF REVENUE

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Springfield IL 62794

217/782-2844

G) Related rulemakings and other pertinent information: None

g) Part(s) (Heading and Code Citations): Service Use Tax, 86 Ill. Adm. Code 160

1) Rulemaking:

- A) Description: Amendments will be made to update the Service Use Tax regulations to reflect new statutory developments, decisional law and Department policies. Some of the highlights of these changes include addition of a new Section in response to enactment of PA 98-0352, which prohibits the sale, possession or use of automated sales suppression devices, or zappers, and amendment of other sections of Part 160 dealing with penalties and interest.
- B) Statutory Authority: 35 ILCS 110/12
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings amending Part 160 during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: These amendments will affect persons subject to the Service Use Tax, including persons required to collect Service Use Tax from Illinois purchasers.
- F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

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217/782-2844

G) Related rulemakings and other pertinent information: Noneh) Part(s) (Heading and Code Citations): Practice and Procedure for Hearings before the Illinois Department of Revenue, 86 Ill. Adm. Code Part 2001) Rulemaking:

- A) Description: Amendments are anticipated to the Department's administrative hearings practice and procedure regulations to reflect the changes to those regulations as the result of the creation of the Independent Tax Tribunal under the Independent Tax Tribunal Act of 2012, 35 ILCS 1010/1 et seq. Amendments will be made to reflect any recent decisional law, statutory changes, and Department policy.
- B) Statutory Authority: 20 ILCS 2505/2505-10
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: All types of businesses, some municipalities and not for profit corporations may be impacted by these proposed changes regarding the creation of the Independent Tax Tribunal to hear certain administrative protests of tax matters.
- F) Agency contact person for information:

Terry D. Charlton
Chief Administrative Law Judge
Illinois Department of Revenue
Office of Administrative Hearings
101 West Jefferson Street – Level 5SW

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

Springfield IL 62702

217/782-6995

- G) Related rulemakings and other pertinent information: Rules of the Independent Tax Tribunal.
- i) Part(s) (Heading and Code Citations): Business District Retailers' Occupation Tax, 86 Ill. Adm. Code 400
- 1) Rulemaking:
- A) Description: A new Part will be promulgated to set out specific procedures and requirements for the business district retailers' occupation tax authorized by PA 93-1053. On November 21, 2013, the Illinois Supreme Court, in Hartney Fuel Oil Co. v. Hamer 2013 IL 115130, invalidated Department rules that retailers had long relied on upon to determine which locally-imposed sales taxes they were required to pay. Proposed rules will provide guidance for retailers to determine what local taxes they incur based on the location where they are "engaged in the business of selling tangible personal property."
- B) Statutory Authority: 65 ILCS 5/11-74.3-6
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Municipalities are authorized to impose this tax within business districts established by those municipalities. All businesses that are engaged in making sales of tangible personal property at retail within a business district where this tax is imposed will be subject to tax.
- F) Agency contact person for information:

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/782-2844

G) Related rulemakings and other pertinent information: None

j) Part(s) (Heading and Code Citations): Business District Service Occupation Tax, 86 Ill. Adm. Code 405

1) Rulemaking:

A) Description: A new Part will be promulgated to set out specific procedures and requirements for the service occupation tax authorized by PA 93-1053.

B) Statutory Authority: 65 ILCS 5/11-74.3-6

C) Scheduled meetings/hearing dates: No schedule has been established at this time.

D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.

E) Effect on small business, small municipalities or not for profit corporations: Municipalities are authorized to impose this tax within business districts established by those municipalities. All businesses that transfer tangible personal property incident to sales of service within a business district where this tax is imposed will be subject to tax.

F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

101 W. Jefferson, 5-500
Springfield IL 62794

217/782-2844

G) Related rulemakings and other pertinent information: None

k) Part(s) (Heading and Code Citations): Liquor Control Act, 86 Ill. Adm. Code 420

1) Rulemaking:

- A) Description: Amendments will be made to Section 420.10 to reflect the provisions of PA 95-634, PA 96-34 and PA 96-38, which changed the gallonage tax rates on beer, wine, cider and spirits effective September 1, 2009 and added provisions regarding licensed winery shippers. In addition, administrative provisions will be added, including new sections for definitions, investigations and hearings, administrative review of Department decisions and confidentiality of tax information.
- B) Statutory Authority: 235 ILCS 5/8-1 et seq.
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Manufacturers and importing distributors of beer, wine, cider and spirits are affected due to the change in tax rates on those items.
- F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

217/782-2844

- G) Related rulemakings and other pertinent information: There are no related rulemakings.

- l) Part(s) (Heading and Code Citations): Bingo License and Tax Act, 86 Ill. Adm. Code 430

1) Rulemaking:

- A) Description: Regulations will be updated to reflect the provisions of PA 93-742, which authorizes the Department to issue 3-year bingo licenses, including regular licenses, limited licenses or senior citizen restricted licenses, and the amendments in PA 95-228, dealing with licensing. The regulations will also be amended to clarify record keeping requirements and the documentation required for a license application.
- B) Statutory Authority: 230 ILCS 25/1
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Entities eligible for bingo licenses will be affected by this rulemaking.
- F) Agency contact person for information:

Paul Caselton
Deputy General Counsel, Income Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

DEPARTMENT OF REVENUE

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217/524-3951

- G) Related rulemakings and other pertinent information: There are no related rulemakings.

- m) Part(s) (Heading and Code Citations): Pull Tabs and Jar Games Act, 86 Ill. Adm. Code 432

1) Rulemaking:

- A) Description: Regulations will be amended to implement the amendments in PA 95-228 dealing with licensing and to clarify record keeping requirements and the documentation required for a license application.
- B) Statutory Authority: 230 ILCS 20/1
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Entities eligible for pull tabs and jar games licenses will be affected by this rulemaking.
- F) Agency contact person for information:

Paul Caselton
Deputy General Counsel, Income Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/524-3951

- G) Related rulemakings and other pertinent information: There are no related rulemakings.

DEPARTMENT OF REVENUE

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- n) Part(s) (Heading and Code Citations): Charitable Games Act, 86 Ill. Adm. Code 435
- 1) Rulemaking:
- A) Description: Regulations will be amended to implement the amendments in PA 95-228 dealing with licensing and to clarify record keeping requirements and the documentation required for a license application.
- B) Statutory Authority: 230 ILCS 30/1
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Entities eligible for a charitable games license will be affected by this rulemaking.
- F) Agency contact person for information:
- Paul Caselton
Deputy General Counsel, Income Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/524-3951
- G) Related rulemakings and other pertinent information: There are no related rulemakings.
- o) Part(s) (Heading and Code Citations): Cigarette Tax Act, 86 Ill. Adm. Code 440
- 1) Rulemaking:

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

- A) Description: Amendments will be made to update the Cigarette Tax Act regulations to reflect new statutory developments, decisional law and Department policies. The Department anticipates amendments to reflect provisions of P.L. 111-154, the federal "Prevent All Cigarette Trafficking Act of 2009;" PA 95-1053 (new definitions; penalties); PA 96-782 (technical clean-up and penalties); PA 97-587 (manufacturer representatives authorized); PA 96-1027 (secondary distributors authorized); PA 97-688 (increased the tax rate for cigarettes); and [anticipated] HB 2494 (Cigarette Retailer Licensing provisions and associated recordkeeping and enforcement requirements). Rulemakings will also be promulgated as part of the Department's continuing effort to codify policies contained in various letter rulings.
- B) Statutory Authority: 20 ILCS 2505/2505-30; 35 ILCS 130/1 et seq.
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Minimal, depending upon what legislation may be enacted.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/782-2844
- G) Related rulemakings and other pertinent information: None
- p) Part(s) (Heading and Code Citations): Cigarette Use Tax Act, 86 Ill. Adm. Code 450

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

- 1) Rulemaking:
- A) Description: Amendments will be made to update the Cigarette Use Tax Act regulations to reflect new statutory developments, decisional law and Department policies. The Department anticipates amendments to these rules to incorporate the changes of PA 95-1053 (new definitions; penalties); PA 96-782 (technical clean-up and penalties); PA 97-587 (manufacturer representatives authorized); PA 96-1027 (secondary distributors authorized); and PA 97-688 (increased the tax rate for cigarettes); and [anticipated] HB 2494 (Cigarette Retailer Licensing provisions and associated recordkeeping and enforcement requirements). Rulemakings will also be promulgated as part of the Department's continuing effort to codify policies contained in various letter rulings.
- B) Statutory Authority: 20 ILCS 2505/2505-80; 35 ILCS 135/1 et seq.
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Minimal, depending upon what specific legislation may be enacted.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/782-2844
- G) Related rulemakings and other pertinent information: None

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

- q) Part(s) (Heading and Code Citations): Hydraulic Fracturing Tax, 86 Ill. Adm. Code 475
- 1) Rulemaking:
- A) Description: A new Part will be promulgated in response to enactment of PA 98-22 and PA 98-23 (Hydraulic Fracturing Regulatory Act, including the Illinois Hydraulic Fracturing Tax).
- B) Statutory Authority: 35 ILCS 450/2-65
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Small businesses may be included in the persons required to file returns, pay taxes and maintain books and records.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/782-2844
- G) Related rulemakings and other pertinent information: There are no related rulemakings.
- r) Part(s) (Heading and Code Citations): Hotel Operators' Occupation Tax Act, 86 Ill. Adm. Code 480
- 1) Rulemaking:

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- A) Description: Amendments will be made to update the Hotel Operators' Occupation Tax Act regulations to reflect new statutory developments, decisional law and Department policies. Rulemakings are also promulgated as part of the Department's continuing effort to codify policies contained in various letter rulings.
- B) Statutory Authority: 20 ILCS 2505/2505-85; 35 ILCS 145/1 et seq.
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Minimal.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/782-2844
- G) Related rulemakings and other pertinent information: None
- s) Part(s) (Heading and Code Citations): Telecommunications Excise Tax, 86 Ill. Adm. Code 495
- 1) Rulemaking:
- A) Description: Regulations will be updated to reflect new statutory provisions, decisional law and Department policy. Examples include:

Regulations that explain the manner in which DSL services are taxed.

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Regulations that explain the telecommunications tax liabilities involved when multiple parties are joined together in different conference calling arrangements.

Amendment of Section 495.100 to clarify the ending date for using alternate apportionment methods for imposing tax on portions of the interstate inter-office channels for private lines.

- B) Statutory Authority: 35 ILCS 630
 - C) Scheduled meetings/hearing dates: No schedule has been established at this time.
 - D) Date Agency anticipates First Notice: We anticipate filing rulemakings to Part 495 during the next six months of this year.
 - E) Effect on small business, small municipalities or not for profit corporations: Retailers of telecommunications and their telecommunications customers will be affected by these regulations.
 - F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/782-2844
 - G) Related rulemakings and other pertinent information: There are no related rulemakings.
- t) Part(s) (Heading and Code Citations): Motor Fuel Tax, 86 Ill. Adm. Code 500
- 1) Rulemaking:

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- A) Description: Regulations will be updated to reflect new statutory provisions (such as anticipated SB 3262, which changes the interest rate for IFTA licensees), new provisions and procedures under the International Fuel Tax Agreement, decisional law, Department policy and procedures, and include regulations requiring electronic filing and payment by licensees.
- B) Statutory Authority: 35 ILCS 505/14
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings to Part 500 during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Motor fuel distributors, suppliers and receivers, as well as persons licensed under the International Fuel Tax Agreement, will be affected by these regulations.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/782-2844
- G) Related rulemakings and other pertinent information: There are no related rulemakings.
- u) Part(s) (Heading and Code Citations): County School Facility Retailers' Occupation Tax, 86 Ill. Adm. Code 600
- 1) Rulemaking:

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- A) Description: A new Part will be promulgated to implement the provisions of PA 95-675 imposing a County School Facility Retailers' Occupation Tax. Regulations are also anticipated in response to PA 98-584 which changes the date for ordinance submission to the Department for local taxes approved by referenda. On November 21, 2013, the Illinois Supreme Court, in *Hartney Fuel Oil Co. v. Hamer* 2013 IL 115130, invalidated Department rules that retailers had long relied on upon to determine which locally-imposed sales taxes they were required to pay. Proposed rules will provide guidance for retailers to determine what local taxes they incur based on the location where they are "engaged in the business of selling tangible personal property."
- B) Statutory Authority: 55 ILCS 5/5-1006.7
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Counties imposing this tax and retailers located in such jurisdictions will be affected by this rulemaking.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/782-2844
- G) Related rulemakings and other pertinent information: New Part 605 implementing a County School Facility Service Occupation Tax is related.

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

- v) Part(s) (Heading and Code Citations): County School Facility Service Occupation Tax, 86 Ill. Adm. Code 605
- 1) Rulemaking:
- A) Description: A new Part will be promulgated to implement the provisions of PA 95-675 imposing a County School Facility Service Occupation Tax. Regulations are also anticipated in response to PA 98-584, which changes the date for ordinance submission to the Department for local taxes approved by referenda.
- B) Statutory Authority: 55 ILCS 5/5-1006.7
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Businesses making sales of service in counties imposing the tax will be minimally affected.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/782-2844
- G) Related rulemakings and other pertinent information: New Part 600 implementing a County School Facility Retailers' Occupation Tax is related.

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

- w) Part(s) (Heading and Code Citations): Tobacco Products Tax Act of 1995, 86 Ill. Adm. Code 660
- 1) Rulemaking:
- A) Description: Amendments will be made to update the Tobacco Products Tax Act regulations to reflect new statutory developments, decisional law and Department policies. These amendments will include changes made by PA 97-688 which increased the tax rate for tobacco products and imposed a new weight-based tax rate on moist snuff. Provisions will also be added to reflect the provisions of PA 98-273, which added a definition of little cigars, taxed these items under the Tobacco Products Tax Act at the rate established for cigarettes, and established specific provisions governing their distribution and reporting. Rules will also be amended to reflect the provisions of [anticipated] HB 2494, which establishes Tobacco Product Retailer Licensing provisions and associated enforcement and recordkeeping requirements. Rulemakings are also promulgated as part of the Department's continuing effort to codify policies contained in various letter rulings.
- B) Statutory Authority: 35 ILCS 143/10-1 et seq.
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Minimal.
- F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

217/782-2844

G) Related rulemakings and other pertinent information: Nonex) Part(s) (Heading and Code Citations): Special County Retailers' Occupation Tax for Public Safety, 86 Ill. Adm. Code 6701) Rulemaking:A) Description: Amendments will be made to update the Special County Retailers' Occupation Tax for Public Safety regulations to reflect new statutory developments, decisional law and Department policies. The rules will also be amended in response to PA 98-584, which changes the date for ordinance submission to the Department for local taxes approved by referenda.B) Statutory Authority: 55 ILCS 5/5-1006.5C) Scheduled meetings/hearing dates: No schedule has been established at this time.D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.E) Effect on small business, small municipalities or not for profit corporations: If imposed by a county after referendum, retailers would be required to pay this tax on sales of tangible personal property.F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/782-2844

DEPARTMENT OF REVENUE

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G) Related rulemakings and other pertinent information: None

y) Part(s) (Heading and Code Citations): Special County Service Occupation Tax for Public Safety, 86 Ill. Adm. Code 680

1) Rulemaking:

A) Description: Amendments will be made to update the Special County Service Occupation Tax for Public Safety regulations to reflect new statutory developments, decisional law and Department policies. The rules will also be amended in response to PA 98-584, which changes the date for ordinance submission to the Department for local taxes approved by referenda. Rulemakings are also promulgated as part of the Department's continuing effort to codify policies contained in various letter rulings.

B) Statutory Authority: 55 ILCS 5/5-1006.5

C) Scheduled meetings/hearing dates: No schedule has been established at this time.

D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.

E) Effect on small business, small municipalities or not for profit corporations: If imposed by a county after referendum, servicepersons would be required to pay this tax on tangible personal property transferred incident to a sale of service.

F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

217/782-2844

G) Related rulemakings and other pertinent information: Nonez) Part(s) (Heading and Code Citations): Non-Home Rule Municipal Retailers' Occupation Tax, 86 Ill. Adm. Code 6931) Rulemaking:

A) Description: Regulations will be promulgated to provide for the administration of the tax, including regulations proposed response to PA 98-584, which changes the date for ordinance submission to the Department for local taxes approved by referenda. Rulemakings are also promulgated as part of the Department's continuing effort to codify policies contained in various letter rulings.

B) Statutory Authority: 65 ILCS 5/8-11-1.3

C) Scheduled meetings/hearing dates: No schedule has been established at this time.

D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.

E) Effect on small business, small municipalities or not for profit corporations: Municipalities imposing this tax and retailers located in such jurisdictions will be affected by this rulemaking.

F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/782-2844

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

G) Related rulemakings and other pertinent information: None

aa) Part(s) (Heading and Code Citations): Non-Home Rule Municipal Service Occupation Tax, 86 Ill. Adm. Code 694

1) Rulemaking:

A) Description: Regulations will be promulgated to provide for the administration of the tax, including regulations proposed response to PA 98-584, which changes the date for ordinance submission to the Department for local taxes approved by referenda. Rulemakings are also promulgated as part of the Department's continuing effort to codify policies contained in various letter rulings.

B) Statutory Authority: 65 ILCS 5/8-11-1.4

C) Scheduled meetings/hearing dates: No schedule has been established at this time.

D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.

E) Effect on small business, small municipalities or not for profit corporations: Municipalities imposing this tax and servicemen located in these jurisdictions will be affected by this rulemaking.

F) Agency contact person for information:

Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/782-2844

G) Related rulemakings and other pertinent information: None

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JULY 2014 REGULATORY AGENDA

bb) Part(s) (Heading and Code Citations): Uniform Penalty and Interest Act, 86 Ill. Adm. Code 700

1) Rulemaking:

- A) Description: The Department will amend the regulations in Part 700 to reflect recent amendments to the Uniform Penalty and Interest Act and Department policies.
- B) Statutory Authority: 20 ILCS 2505/2505-795
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities and not for profit corporations: These rulemakings will provide guidance for any business or not for profit corporation that incurs tax liabilities potentially subject to penalty or interest obligations under the Uniform Penalty and Interest Act.
- F) Agency contact person for information:
- Paul Caselton
Deputy General Counsel, Income Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/524-3951
- G) Related rulemakings and other pertinent information: None

cc) Part(s) (Heading and Code Citations): General Rules for All Taxes, 86 Ill. Adm. Code 800

1) Rulemaking:

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

- A) Description: Rules will be proposed in either a new Part Governing Payment of Taxes by Credit Cards, 86 Ill. Adm. Code 780 or in Part 800 in response to PA 98-425, which authorizes the Department to promulgate rules allowing payment of taxes by credit cards.
- B) Statutory Authority: PA 98-425 and applicable provisions of 20 ILCS 2505/1 et seq. (rulemaking authority for various taxes)
- C) Scheduled meetings/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Small businesses or not for profit corporations may be affected positively by these rules, since they offer an alternative method of tax payment.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794

217/782-2844
- G) Related rulemakings and other pertinent information: None

dd) Part(s) (Heading and Code Citations): Coin-Operated Amusement Device and Redemption Machine Tax, 86 Ill. Adm. Code 460.

- 1) Rulemaking:

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

- A) Description: The rules will be amended in response to PA 97-1126, which changed the definition of "redemption machine." The regulations will also be updated to reflect new statutory developments, decisional law and Department policies.
- B) Statutory Authority: 35 ILCS 510; 20 ILCS 2505/2505-105
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing rulemakings during the next six months of this year.
- E) Effect on small business, small municipalities or not for profit corporations: Businesses offering redemption machines will be affected by this rulemaking.
- F) Agency contact person for information:
- Jerilynn Gorden
Deputy General Counsel, Sales and Excise Tax
Illinois Department of Revenue
101 W. Jefferson, 5-500
Springfield IL 62794
- 217/782-2844
- G) Related rulemakings and other pertinent information: None

ee) Part(s) (Heading and Code Citations): The Illinois Liquor Control Commission, 11 Ill. Adm. Code 100

1) Rulemaking:

- A) Description: The proposed rules will clarify the intention of the legislature behind the "Three-Tier" system that retailers must purchase alcoholic liquor from licensed distributors only. Retailers may not purchase alcoholic liquors from other retailers or directly from

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

manufacturers unless exempt. Retailers also may not sell alcoholic liquor for future or subsequent resale.

Per the Open Meetings Act and the proposed rules, Commissioners may attend meetings through audio or video teleconferencing under certain conditions noted in the rule. Furthermore, the proposed rules will permit public attendance and comment at Commission meetings.

The proposed rules will remove the ambiguity of the Illinois Liquor Control Act's license eligibility statute by stating that the owners/officers/members of a revoked corporation, limited liability company, etc., are considered revoked persons in the same capacity as the revoked business entity.

The proposed rules allow the Commission to delegate to the administrative staff of the Commission the authority to act on its behalf by an official act.

The proposed rules define "alcoholic liquor" and the scope of the Illinois Liquor Control Act as it pertains to products and persons.

The proposed rules remove the requirement for multi-use facilities to invoice and store their alcoholic liquor separately within one central location by State liquor license number for investigative purposes.

The proposed rules clarify the requirements for hotels/motels to be permitted to sell alcohol via mini bars and room service.

The proposed rules delineate the jurisdictions of state and local regulative bodies as they pertain to boat licenses and establish requirements of boat liquor license holders.

The proposed rules define an "auction liquor license" and delineate the privileges it grants.

The proposed rules list the conditions that must be met before an in-state and out-of-state maker of wine can be permitted to sell its own manufactured wine direct to retail license holders.

DEPARTMENT OF REVENUE

JULY 2014 REGULATORY AGENDA

The proposed rules list the conditions that must be met before an in-state and out-of-state maker of beer can be permitted to sell its own manufactured wine direct to retail license holders.

The proposed rules prohibit the importation of alcoholic liquor into Illinois for a non-personal or commercial use without first obtaining a license to import issued by the Commission, and these proposed rules list the conditions under which this may be permitted.

The proposed rules will outline guidelines to regulate product tastings, samplings, and test marketing with regards to serving amounts, entrance fees, tracking, extraneous materials, licenses, and general operation.

- B) Statutory Authority: Section 3-12(a)(2) of the Liquor Control Act [235 ILCS 5/3-12(a)(2)]
- C) Scheduled meeting/hearing dates: No schedule has been established at this time.
- D) Date Agency anticipates First Notice: We anticipate filing sometime in the next three months.
- E) Effect on small businesses, small municipalities or not for profit corporations: This rulemaking will affect holders of retail liquor licenses.
- F) Agency contact person for information:

Richard Haymaker
Chief Legal Counsel
Liquor Control Commission
100 W. Randolph, Suite 7-801
Chicago, IL 60601

312/814-1804
- G) Related rulemakings and other pertinent information: None

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received during the period of July 1, 2014 through July 7, 2014. The Department of Human Services rulemakings are scheduled for review at the Committee's July 15, 2014 meeting and the others at the August 12, 2014 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>
8/8/14	<u>Department of Human Services</u> , Provider Requirements, Type Services and Rate of Payment (89 Ill. Adm. Code 686)	3/14/14 38 Ill. Reg. 5941	7/15/14
8/15/14	<u>Department of Human Services</u> , Program Description (89 Ill Adm. Code 676)	3/14/14 38 Ill. Reg. 5935	7/15/14
8/15/14	<u>Department of Human Services</u> , Eligibility (89 Ill. Adm. Code 682)	3/14/14 38 Ill. Reg. 5937	7/15/14
8/15/14	<u>Department of Human Services</u> , Service Planning and Provision (89 Ill. Adm. Code 684)	3/14/14 38 Ill. Reg. 5939	7/15/14
8/15/14	<u>State Board of Education</u> , Programs for the Preparation of Superintendents in Illinois (23 Ill. Adm. Code 33)	4/11/14 38 Ill. Reg. 7822	8/12/14
8/15/14	<u>Office of the State Fire Marshal</u> , Boiler and Pressure Vessel Safety (41 Ill. Adm. Code 120)	4/11/14 38 Ill. Reg. 7741	8/12/14

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

8/20/14

Department of Corrections, Secure Residential
Youth Care Facilities (Repealer) (20 Ill Adm.
Code 801)

4/25/14

38 Ill. Reg.
8574

8/12/14

ILLINOIS ADMINISTRATIVE CODE
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