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NOTICE OF PROPOSED AMENDMENTS

1) **Heading of the Part:** Pay Plan

2) **Code Citation:** 80 Ill. Adm. Code 310

3) **Section Numbers:**
   - 310.50 Amendment
   - 310.80 Amendment
   - 310.90 Amendment
   - 310.100 Amendment
   - 310.230 Amendment
   - 310.240 Amendment
   - 310.260 Amendment
   - 310.280 Amendment
   - 310.290 Amendment
   - 310.460 Amendment
   - 310.470 Amendment
   - 310.480 Amendment
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   - 310.500 Amendment
   - 310.Appendix Table L Amendment
   - 310.Appendix Table T Amendment
   - 310.Appendix Table U Amendment
   - 310.Appendix B Amendment
   - 310.Appendix C Amendment
   - 310.Appendix D Amendment
   - 310.Appendix G Amendment

4) **Statutory Authority:** Authorized by Sections 8 and 8a of the Personnel Code [20 ILCS 415/8 and 20 ILCS 415/8a].

5) **A Complete Description of the Subjects and Issues Involved:** In the Table of Contents, the heading for Section 310.240 is amended.

   In Section 310.50 Definitions, bilingual pay and reclassification are defined, and the Pay Plan Code N is clarified to specifically name the Illinois School for the Deaf.

   Section 310.80 Increases in Pay (e)(4) is added to explain how to implement a pay increase following a reclassification and (f) is amended to reflect that the effective date for the 4% adjustment increase is December 2, 2005.
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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Section 310.90 Decreases in Pay is amended to reflect pay grade as defined in Section 310.50 and (f) is amended to reflect how to implement a pay decrease following a reclassification.

Section 310.100 Other Pay Provisions (d)(1) is amended replacing the period with a dash. In the same Section, (h) is amended to reflect the pay treatment of the Disaster Leave with Pay and the Family Responsibility Leave, and to reorder the placement of Educational Leave. In the same Section, (l) is amended to reflect the definition of bilingual pay.

Section 310.230 Part-Time Daily or Hourly Special Services Rate is amended to clarify the explanation of the part-time rates and their calculation. With that, the titles with rates calculated in the manner described in Section 310.240 are removed, leaving the title’s rates not calculated from an assigned monthly rate.

Section 310.240 Hourly Rate is amended to reflect the new Section heading, to include the conversion to daily rates, and to clarify that the basis of the conversions is the monthly salary.

Section 310.260 Trainee Rate is amended to include the location of the definition of Trainee Program in the Personnel Rules, that some trainee rates are negotiated, that trainee rates for merit compensation system Trainee Programs are recommended by the agency head where the Trainee Program is established, that increases were suspended for non-union positions and employees, and that the non-bargaining-unit rates will be adjusted by a 4% increase effective December 2, 2005, and the 4% adjustment increases will be made to non-bargaining-unit employees' base salaries effective December 2, 2005.

Section 310.280 Designated Rate is amended to reflect the request by the Department of Commerce and Economic Opportunity to increase the designated rate for the Private Secretary II, position number 34202-42-00-000-01-02, to $62,400. The same Section is amended to remove the abolished Medical Administrator V position, position number 26406-10-76-000-00-01, which had been assigned the $186,000 designated rate within the Department of Human Services.

Section 310.290 Out-of-State or Foreign Service Rate is amended to clarify the reason the rates are required, to add the residency requirement, to include the 4% adjustment increases to employees' base salaries effective December 2, 2005, to specify the calculation of the rates for the differing states and that the listed foreign service rates are adjusted monthly. In the same section, the table is amended to include the July 1, 2005
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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and December 2, 2005 effective dates, the minimum and maximum column headings, and the December 2, 2005 minimum and maximum.

In Section 310.460 Other Pay Increases, dashes are included in each subsection, the subsections paragraphs are moved up to the subsection heading, and (e) is added to explain how to implement a pay increase following a reclassification.

Section 310.470 Adjustment is amended to reflect that the 4% adjustment increase effective December 2, 2005 does not affect employees' creditable service date.

In Section 310.480 Decreases in Pay, (f) is amended to reflect how to implement a pay decrease following a reclassification.

Section 310.490 Other Pay Provisions (c)(2)(A) and (B)(d)(1), (2) and (3) are amended so that the headings are followed by the dash for consistency. In the same Section, (h) is amended to reflect the pay treatment of the Disaster Leave with Pay and the Family Responsibility Leave, and to reorder the placement of Educational Leave. In the same Section, (i) has a comma added for clarity. In the same Section, (m) is amended to reflect the definition of bilingual pay.

In Section 310.500 Definitions, bilingual pay and reclassification are defined.

Section 310.Appendix A Table L RC-008 (Boilermakers) is amended to include the January 1, 2006 rates in the Northern and Central regions. Effective January 1, 2006, the Boiler Safety Specialist title is paid an additional 4.00% above the prevailing rate of wages for the employees on the standard pension formula based on the Agreement between the Department of Central Management Services and the International Brotherhood of Boiler Makers – Iron Shipbuilders, Blacksmiths, Forgers, and Helpers that was signed December 6, 2004.

Section 310.Appendix A Table T HR-010 (Teachers of Deaf, IFT) is amended to include the Title, Title Code, Bargaining Unit, and Pay Plan Code, to remove the Note between the tables, and to better explain the implementation of bilingual pay.

Section 310.Appendix A Table U HR-010 (Teachers of Deaf, Extracurricular Paid Activities) is amended to include the Title, Title Code, Bargaining Unit, and Pay Plan Code.

Section 310.Appendix B Schedule of Salary Grades – Monthly Rates of Pay for Fiscal Year 2006 is amended to include the July 1, 2005 effective date to the existing table, the
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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salary grade steps table effective December 2, 2005, and the 4% adjustment increases to employees' base salaries effective December 2, 2005.

Section 310.Appendix C Medical Administrator Rates for Fiscal Year 2006 is amended to include the July 1, 2005 effective date to the existing table, the titles' salaries table effective December 2, 2005, and the 4% adjustment increases to employees' base salaries effective December 2, 2005.

Section 310.Appendix D Merit Compensation System Salary Schedule for Fiscal Year 2006 is amended to include the July 1, 2005 effective date to the existing table, the salary ranges' salaries table effective December 2, 2005, and the 4% adjustment increases to employees' base salaries effective December 2, 2005.

Section 310.Appendix G Broad-Band Pay Range Classes Salary Schedule for Fiscal Year 2006 is amended to include the July 1, 2005 effective date to the existing table, the titles' salaries table effective December 2, 2005, and the 4% adjustment increases to employees' base salaries effective December 2, 2005.

6) Will these proposed amendments replace any emergency amendments currently in effect? Some of the amendments to Sections 310.80, 290, 470, and Appendices B, C, D, and G are companion, but not identical, proposed amendments to emergency amendments at 29 Ill. Reg. 20554. With the amendments proposed for Sections 310.230 and 240, reference to the December 2, 2005 adjustment for daily and hourly rates is unnecessary.

7) Does this rulemaking contain an automatic repeal date? No

8) Does this rulemaking contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? Yes

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10) **Statement of Statewide Policy Objectives**: These amendments to the Pay Plan affect only the employees subject to the Personnel Code and do not set out any guidelines that affect local or other jurisdictions in the State.

11) **Time, Place, and Manner in which interested persons may comment on this proposed rulemaking**: 

   Mr. Jason Doggett  
   Acting 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  
   217/782-7964  
   Fax: 217/524-4570

12) **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

13) **Regulatory Agenda on which this rulemaking was summarized**: Some of this rulemaking was referenced in the July 2005 Regulatory Agenda.

14) **Does this amendment require the review 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 Proposed Amendments begins on the next page.
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE B: PERSONNEL RULES, PAY PLANS, AND
POSITION CLASSIFICATIONS
CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 310
PAY PLAN

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Section
310.20  Policy and Responsibilities
310.30  Jurisdiction
310.40  Pay Schedules
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 for Fiscal Year 2006
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)

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310.205 Introduction
310.210 Prevailing Rate
310.220 Negotiated Rate
310.230 Part-Time Daily or Hourly Special Services Rate
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310.260 Trainee Rate
310.270 Legislated and Contracted Rate
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310.290 Out-of-State or Foreign Service Rate
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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

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310.TABLE K  RC-023 (Registered Nurses, INA)
310.TABLE L  RC-008 (Boilermakers)
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310.TABLE N  RC-010 (Professional Legal Unit, AFSCME)
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310.TABLE R  RC-042 (Residual Maintenance Workers, AFSCME)
310.TABLE S  HR-012 (Fair Employment Practices Employees, SEIU)
            (Repealed)
310.TABLE T  HR-010 (Teachers of Deaf, IFT)
310.TABLE U  HR-010 (Teachers of Deaf, Extracurricular Paid Activities)
310.TABLE V  CU-500 (Corrections Meet and Confer Employees)
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310.TABLE AA NR-916 (Department of Natural Resources, Teamsters)
310.TABLE AB VR-007 (Plant Maintenance Engineers, Operating Engineers)
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310.APPENDIX B  Schedule of Salary Grades – Monthly Rates of Pay for Fiscal Year 2006
310.APPENDIX C  Medical Administrator Rates for Fiscal Year 2006
310.APPENDIX D  Merit Compensation System Salary Schedule for Fiscal Year 2006
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 for Fiscal Year 2006

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

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

Section 310.50 Definitions

The following are definitions of terms and are for purposes of clarification only. They affect the Schedule of Rates (Subpart B), Negotiated Rates of Pay (Appendix A), and the Schedule of Salary Grades (Appendix B). 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.

"Base Salary" – A dollar amount of pay specifically designated in the Schedule of Salary Grades (Appendix B) or Schedule of Rates (Subpart B). Base salary does not include overtime pay or 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.

"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. A new creditable service date will follow an increase of a step or more except for the following actions:
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Superior performance increase.

A reevaluation resulting in a salary increase less than a step in the former pay grade.

Reallocation resulting in a salary increase less than a step increase in the former pay grade.

Adjustments as provided for in Section 310.80(f) that are approved to correct errors or oversights. (A new creditable service date will follow Section 310.80(f) adjustments in the best interest of the agency, unless the Director of Central Management Services determines the change in creditable service date to be inequitable.)

"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 him/her during normal schedule of work.

"Entrance Salary" – The initial base salary assigned to an employee on 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-hiring Rate" – An in-hiring rate is a minimum rate/step for a class that is above the normal minimum of the range, as approved by the Director of Central Management Services after a review of competitive market starting rates for similar classes.

"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:
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7 = Salary Grade regular pension formula rate
8 = Salary Grade alternative pension formula rate
9 = Salary Grade maximum-security institution rate
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 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 an existing 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
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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 Grade" – The system of pay practices applied to specific positions or employees not represented by a bargaining unit, and not in the Merit Compensation System, which includes Broad-Band positions.

"Salary Range" – The dollar value represented by Steps 1c through 8 of a pay grade assigned to a class title, effective January 1, 2002.

"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.)

"Superior Performance" – Performance characterized by work results substantially above a satisfactory level.

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

"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 of the Department of Central Management Services rules.

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

Section 310.80 Increases in Pay

Except as otherwise provided for in this Section, for employees occupying positions in classes that are paid in conformance with the Schedule of Negotiated Rates (Appendix A) and the Schedule of Salary Grades (Appendix B), increases shall be granted as follows and will become effective the first day of the pay period following the date of approval:

a) Satisfactory Performance Increase –
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1) Each employee who has not attained Step 8 of the relevant pay grade, and whose level of performance has been at a satisfactory level of competence, shall be successively advanced in pay to the next higher step in the pay grade after one year of creditable service in the same class. (Effective July 1, 2003, step increases are suspended for non-union positions and employees.)

2) A satisfactory performance increase shall become effective on the first day of the month within which the required period of creditable service is reached.

3) No satisfactory performance increase may be given after the effective date of separation.

b) Withholding Satisfactory Performance Increase – As an inducement toward attainment of satisfactory level of competence, satisfactory performance increases may be withheld from the employee who has not achieved a satisfactory level of performance. Such action must be supported by:

1) A performance record showing less than satisfactory performance. This must be prepared by the appropriate supervisor, discussed with the employee and approved by the agency head prior to the date the increase would otherwise become effective. The performance record will not be invalidated by refusal of an employee to sign. In such cases, an explanatory comment shall be made on the record by the supervisor. This record will be preserved by the agency.

2) Notice of withholding of satisfactory performance increases to the Department of Central Management Services – It shall be reported upon completion of action required by subsection (b)(1), but not later than the submission of the payroll reflecting the denial of the increase.

c) Redetermination – A satisfactory performance increase previously withheld shall be granted when the cause for withholding has been eliminated. Redetermination must be made at least annually. In such cases the increases will be effective the first day of the month following date of approval and will be preceded by the preparation and filing of a Performance Record within the agency indicating the attainment of satisfactory level of competence.

d) Superior Performance Increase –
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1) The head of an agency may grant a superior performance increase to an employee who characteristically carries out his/her work activities in such a way that the results are substantially above a satisfactory level of performance.

2) An employee shall be eligible for a superior performance increase after six months continuous service. A minimum of 18 months must elapse between superior performance increases. A superior performance increase shall be for one step in the relevant pay grade. (Effective July 1, 2003, step increases are suspended for non-union and union positions and employees.)

3) A superior performance increase does not affect the creditable service anniversary date. A performance record supporting a superior performance increase award shall be retained by each agency head, and shall be available to the Director of Central Management Services upon request.

4) During the fiscal year, the number of superior performance increases in an agency should not exceed one out of five employees.

e) Other Pay Increases –

1) Promotion and Reallocation –

   A) Normally, upon promotion or reallocation, an employee shall be advanced to the lowest step in the new grade that represents at least a full step increase in the former grade. When an employee is promoted from Step 8 after February 15, 2002, the employee shall be paid at the lowest step rate in the new range that results in an increase equal to at least 3%. To compute this, add 3% to the employee's current rate at Step 8 (then include longevity if the employee is receiving an increased rate based on longevity). Then place the employee on the lowest step in the new range that is at least equivalent to that amount.

   B) Any deviation requires prior written approval of the Director of Central Management Services. In determining the appropriateness of a request for a special salary treatment by an employing agency,
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the Director of Central Management Services will consider whether the need for the special salary treatment is substantial, whether the action is consistent with the treatment of other similar situations, and whether the action is equitable in view of the particular circumstances prompting the request.

2) Reevaluation – If a higher pay grade is assigned to a class, the employee occupying the position in the class shall be advanced to the lowest step in the new grade that represents an increase in pay. If an employee becomes eligible for a satisfactory performance increase as a result of the reevaluation, a one-step increase will be granted immediately.

3) Separation and Subsequent Appointment – Upon separation from a position of a given class and appointment within four calendar days to a position in a higher pay grade, an increase shall be given under the conditions and requirements applicable to promotions.

4) Reclassification – If the class to which the position is being moved has a higher pay grade, the employee's base salary is advanced to the salary in the new pay grade that represents the least increase in pay. If this new salary is less than the difference between Step 7 and Step 8 in the previous pay grade and the employee has been paid the base salary in Step 8 of the previous pay grade for longer than one year, the new salary is advanced one step from the salary in the new pay grade representing the least increase.

f) Adjustment – An employee may receive an upward adjustment in his/her base salary for the purpose of correcting a previous error, oversight or when the best interest of the agency and the State of Illinois will be served. Adjustments must have the prior approval of the Director of Central Management Services. In determining the appropriateness of a request for a salary adjustment by an employing agency, the Director of Central Management Services will consider whether the need for the adjustment is substantial, whether the action is consistent with the treatment of other similar situations, and whether the action is equitable in view of the particular circumstances prompting the request. The effective date for the 4% adjustment increase effective December 2, 2005 is as stated.

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

Section 310.90 Decreases in Pay
Employees other than those whose base salaries are determined by the Schedule of Rates (Subpart B) shall have their salaries reduced only as specified below and shall become effective the first day of the pay period following date of approval:

a) Demotion for Cause to a Lower Class – Upon demotion, the employee's base salary will be reduced to Step 8 of the paysalary grade for the lower class if the current base salary is in excess thereof, or to the step in the lower paysalary grade which provides the salary nearest in amount, but less than, the current base salary, except that an employee demoted during a probationary period following promotion will have his/her salary reduced to the step in the lower paysalary grade which represents the salary had the employee not been promoted, and his/her previous creditable service date will be restored.

b) Position Reallocated to a Lower Class – The employee's base salary will be reduced to Step 8 of the lower paysalary grade, if in excess thereof, or to the step in the lower paysalary grade nearest in amount to, but in no case more than, the current base salary. However, as provided in Section 8(a) of the Personnel Code, the pay for an employee whose position is reallocated because of loss of duties and responsibilities after his/her appointment to such position, shall not be required to be lowered to an exact step for a period of one year. Where the base salary is identical to an exact step in the lower range, he/she shall be placed on this step with no further reduction required. An employee's creditable service date will not be affected.

c) Voluntary Reduction to a Lower Class – Upon the voluntary reduction of an employee to a vacant position in a class having a lower paysalary grade than the class from which the reduction was made, the employee's base salary will be reduced to Step 8 of the lower paysalary grade if in excess thereof, or to the step in the lower paysalary grade which provides the base salary nearest in amount, but less than, the current base salary, except that an employee who voluntarily requests a reduction to a lower class during a probationary period following promotion will have his/her salary reduced to the step in the paysalary grade that which represents the salary had the employee not been promoted, and his/her previous creditable service date will be restored.

d) Assignment of a Lower PaySalary Grade to a Class – Upon assignment, an employee's base salary will be that step in the new paysalary grade nearest to, but not greater in amount than, the that step being vacated in the former paysalary grade.
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e) Adjustment – An employee may receive a downward adjustment in his/her base salary for the purpose of correcting a previous error or oversight or when the best interest of the agency and the State of Illinois will be served. Adjustments must have the prior approval of the Director of Central Management Services in writing. In determining the appropriateness of a request for a salary adjustment by an employing agency, the Director of Central Management Services will consider whether the need for the adjustment is substantial, whether the action is consistent with the treatment of other similar situations, and whether the action is equitable in view of the particular circumstances prompting the request.

f) Reclassification – If the class to which the position is being moved has a lower pay grade, the employee's base salary will be the salary in the new pay grade nearest to, but not greater than, the employee's former salary. As provided in Section 8(a) of the Personnel Code, the pay for an employee whose position is reclassified shall not be lowered for a period of one year. If the base salary is identical to an exact step in the lower range, he/she shall be placed on this step with no further reduction required. An employee's creditable service date will not be affected.

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

Section 310.100 Other Pay Provisions

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 Salary – Normally, upon original entry to State service, an employee's base salary will be at Step 1c of the pay grade.

1) Qualifications Above Minimum Requirements –

A) If a candidate possesses directly related training and experience in excess of the minimum requirements of the class specification, the entrance salary may be up to Step 3 as determined by the employing agency. The salary offered should not provide more than a 10% increase over the candidate's current salary.
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B) Qualifications above the minimum requirements shall be documented to support an entrance salary higher than Step 1c. An entrance salary higher than Step 3 must have prior approval from the Director of Central Management Services.

2) 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.

3) 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.

c) Differential and Overtime Pay – An eligible employee may have an amount added to his/her 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 – An employee may be paid an amount in addition to his/her 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.

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 – 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. 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.

3) Incentive Pay – An employee may be paid an amount in addition to his/her 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 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) Extra Duty Pay – An employee may be paid an amount in addition to his/her base salary for service in addition to the regular work schedule on a special work assignment. Additional compensation will be at a rate and in a manner 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.

d) Equivalent Earned Time –

1) Eligibility – Employees who are non-union, exempt under the Federal
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Fair Labor Standards Act, and in positions not eligible for overtime compensation may receive equivalent earned time for hours worked in excess of 40 actual work hours in a work week.

2) Accrual –

A) Employees who are eligible for equivalent earned time shall request that time before working in excess of 40 actual work hours in a work week. Requests for equivalent earned time may be granted by the agency at its discretion, considering its operating needs. Equivalent earned time shall be accrued at straight time only to a maximum of 120 hours in any fiscal year.

B) Equivalent earned time will accrue in no less than one-half hour increments. Time spent in travel outside the normal work schedule shall not be counted toward accrual of equivalent earned time.

3) Compensation – Any approved equivalent earned time shall be taken at a time convenient to the employee and consistent with the operating needs of the agency. This time may not be carried over from one fiscal year to another fiscal year. At no time is equivalent earned time to be converted into cash payment or transferred from one agency to another agency.

e) 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.

f) 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.

g) 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
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of computation is explained in Section 310.70(a) of this Part.

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 his/her regular work hours will be to use his/her 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.

h) Salary Treatment Upon Return From Leave – An employee returning from Military Leave, Peace Corps Leave, Service-Connected Disability Leave, Educational Leave, Disaster Services Leave with Pay, Family Responsibility Leave, Leave to accept a Temporary, Emergency, Provisional, Exempt or Trainee position, Educational Leave, or Leave to serve in domestic peace or job corps will be placed on the step that reflects satisfactory performance increases to which he/she would have been entitled during his/her period of leave. Creditable service date will be maintained. An employee returning to his/her former pay grade from any other leave of over 14 days will be placed at the step on which he/she was situated prior to his/her leave, and his/her creditable service date will be extended by the duration of the leave.

i) 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 his/her 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 his/her creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.

j) Reinstatement – The salary upon reinstatement of an employee will be as
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determined by the employing agency and approved by the Director of Central Management Services. This salary should not provide more than a 10% increase over the candidate's current salary or exceed the current value of the salary step held in the position where previously certified. In no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the salary range.

k) Extended Service Payment –

1) Effective July 1, 2001, 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. (Effective July 1, 2003, this increase is suspended for non-union positions and employees.)

2) Effective July 1, 2001, 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. (Effective July 1, 2003, this increase is suspended for non-union positions and employees.)

l) Bi-lingual Pay – Effective July 1, 2000, individual positions whose job descriptions require the use of sign language, a second language or 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.

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

SUBPART B: SCHEDULE OF RATES

Section 310.230 Part-Time Daily or Hourly Special Services Rate

The rate of pay as approved by the Director of Central Management Services for persons employed on a consultative or part-time basis requiring irregular hours of work and not listed below shall be calculated using the conversion method in Section 310.240 shall be as listed below, except the total compensation of an employee in any given month shall not exceed the monthly rate of Step 5 of the pay grade for the title as shown in the Schedule of Salary Grades (Appendix B) of this Part if the class title is subject to the Schedule of Salary Grades, or Step 5 of the negotiated salary range for classes of positions shown in Section 310.220 or 75% of the maximum rate of those classes of positions subject to the provisions of the Merit Compensation
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**System (Subpart C).**

<table>
<thead>
<tr>
<th>Position</th>
<th>Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Technician II</td>
<td>14.10 to 19.49 (hourly)</td>
</tr>
<tr>
<td>Building/Grounds Laborer</td>
<td>6.50 (hourly)</td>
</tr>
<tr>
<td>Building/Grounds Lead I</td>
<td>6.50 to 7.00 (hourly)</td>
</tr>
<tr>
<td>Building/Grounds Lead II</td>
<td>6.50 to 8.00 (hourly)</td>
</tr>
<tr>
<td>Building/Grounds Maintenance Worker</td>
<td>6.50 (hourly)</td>
</tr>
<tr>
<td>Chaplain I</td>
<td>49 to 70 (daily)</td>
</tr>
<tr>
<td>Chemist I</td>
<td>49 (daily)</td>
</tr>
<tr>
<td>Conservation/Historic Preservation Worker</td>
<td>6.50 to 9.00 (hourly)</td>
</tr>
<tr>
<td>Conservation/Historic Preservation Worker (2nd season—site interpretation)</td>
<td>6.50 to 9.00 (hourly)</td>
</tr>
<tr>
<td>Conservation/Historic Preservation Worker (3rd season—site interpretation)</td>
<td>6.50 to 9.00 (hourly)</td>
</tr>
<tr>
<td>Dentist I</td>
<td>70 to 150 (daily)</td>
</tr>
<tr>
<td>Dentist II</td>
<td>100 to 185 (daily)</td>
</tr>
<tr>
<td>Educator</td>
<td>49 to 85 (daily)</td>
</tr>
<tr>
<td>Educator-Aide</td>
<td>49 (daily)</td>
</tr>
<tr>
<td>Guard II</td>
<td>67 to 84 (daily)</td>
</tr>
<tr>
<td>Guard III</td>
<td>75 to 96 (daily)</td>
</tr>
<tr>
<td>Hearing and Speech Advanced Specialist</td>
<td>15 to 30 (hourly)</td>
</tr>
<tr>
<td>Hearings Referee</td>
<td>75 to 200 (daily)</td>
</tr>
<tr>
<td>Janitor I</td>
<td>6.50 (hourly)</td>
</tr>
<tr>
<td>Labor Maintenance Lead-Worker</td>
<td>6.50 (hourly)</td>
</tr>
<tr>
<td>Laborer (Maintenance)</td>
<td>7.05 to 8.00 (hourly)</td>
</tr>
<tr>
<td>Maintenance Worker</td>
<td>6.50 (hourly)</td>
</tr>
<tr>
<td>Occupational Therapist Program Coordinator</td>
<td>49 to 160 (daily)</td>
</tr>
<tr>
<td>Office Aide</td>
<td>10.45 to 13.46 (hourly)</td>
</tr>
<tr>
<td>Office Assistant</td>
<td>12.18 to 16.04 (hourly)</td>
</tr>
<tr>
<td>Office Associate</td>
<td>12.24 to 16.42 (hourly)</td>
</tr>
<tr>
<td>Office Clerk</td>
<td>11.55 to 15.08 (hourly)</td>
</tr>
<tr>
<td>Optometrist</td>
<td>15 to 35 (hourly)</td>
</tr>
<tr>
<td></td>
<td>50 to 160 (daily)</td>
</tr>
</tbody>
</table>
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**NOTICE OF PROPOSED AMENDMENTS**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Rate Conversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>100 to 300 (daily)</td>
</tr>
<tr>
<td>Physician Specialist (A)</td>
<td>20 to 60 (hourly)</td>
</tr>
<tr>
<td></td>
<td>100 to 325 (daily)</td>
</tr>
<tr>
<td>Physician Specialist (B)</td>
<td>20 to 70 (hourly)</td>
</tr>
<tr>
<td></td>
<td>100 to 350 (daily)</td>
</tr>
<tr>
<td>Physician Specialist (C)</td>
<td>20 to 105 (hourly)</td>
</tr>
<tr>
<td></td>
<td>100 to 360 (daily)</td>
</tr>
<tr>
<td>Physician Specialist (D)</td>
<td>20 to 115 (hourly)</td>
</tr>
<tr>
<td></td>
<td>100 to 370 (daily)</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>50 to 125 (daily)</td>
</tr>
<tr>
<td>Psychologist I</td>
<td>49 to 80 (daily)</td>
</tr>
<tr>
<td>Psychologist II</td>
<td>49 to 125 (daily)</td>
</tr>
<tr>
<td>Psychologist III</td>
<td>49 to 150 (daily)</td>
</tr>
<tr>
<td>Recreation Worker-I</td>
<td>6.50 (hourly)</td>
</tr>
<tr>
<td></td>
<td>49 (daily)</td>
</tr>
<tr>
<td>Registered Nurse-I</td>
<td>49 to 54 (daily)</td>
</tr>
<tr>
<td>Registered Nurse-I (2nd or 3rd shift)</td>
<td>49 to 56 (daily)</td>
</tr>
<tr>
<td>Registered Nurse-I (Cook County)</td>
<td>49 to 58 (daily)</td>
</tr>
<tr>
<td>Registered Nurse-I (Cook County—2nd or 3rd shift)</td>
<td>49 to 59 (daily)</td>
</tr>
<tr>
<td>Registered Nurse-II</td>
<td>49 to 58 (daily)</td>
</tr>
<tr>
<td>Registered Nurse-II (2nd or 3rd shift)</td>
<td>49 to 59 (daily)</td>
</tr>
<tr>
<td>Registered Nurse-II (Cook County)</td>
<td>49 to 60 (daily)</td>
</tr>
<tr>
<td>Registered Nurse-II (Cook County—2nd or 3rd shift)</td>
<td>49 to 62 (daily)</td>
</tr>
<tr>
<td>Revenue Tax Specialist-I</td>
<td>14.10 to 19.49 (hourly)</td>
</tr>
<tr>
<td></td>
<td>106 to 146 (daily)</td>
</tr>
<tr>
<td>Social Worker-II</td>
<td>49 to 75 (daily)</td>
</tr>
<tr>
<td>Social Worker-III</td>
<td>49 to 80 (daily)</td>
</tr>
<tr>
<td>Student Intern</td>
<td>6.50 to 13.04 (hourly)</td>
</tr>
<tr>
<td>Student Worker</td>
<td>6.50 to 10.28 (hourly)</td>
</tr>
<tr>
<td>Technical Advisor-II</td>
<td>32 to 35 (hourly)</td>
</tr>
<tr>
<td>Technical Advisor-III</td>
<td>32 to 60 (hourly)</td>
</tr>
<tr>
<td>Veterinarian-II</td>
<td>95 to 130 (daily)</td>
</tr>
</tbody>
</table>

(Source: Amended at 30 Ill. Reg. _______, effective ____________)

| Section 310.240 Daily or Hourly Rate Conversion |

Rates of pay for employees whose work is of an irregular nature and whose compensation is based on a daily or hourly rate shall be computed as follows:
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For classes having salary ranges consisting of steps—

a) **Daily Rate Conversion** – Conversion of the applicable monthly salary to an annual amount and dividing the result by the number of working days in a year according to the normal work schedule of that class for the agency.

b) **Hourly Rate Conversion** – Conversion of the applicable monthly salary step to an annual amount and dividing the result by the number of working hours in a year according to the normal work schedule of that class for the agency.

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

**Section 310.260 Trainee Rate**

Rates of pay for employees working in trainee classes or in other classes pursuant to a Trainee Program (80 Ill. Adm. Code 302.170) shall conform to those set forth in the applicable Trainee Program, or to pay grades approved for or pay grades negotiated for such training classes. **Merit compensation system Trainee Program rates, which are recommended by the agency head where the Trainee Program is established, will normally be less than the entrance rate for the class for which training is being conducted unless otherwise approved by the Director of Central Management Services.** (Effective July 1, 2003, increases are suspended for non-union positions and employees.) Effective December 2, 2005, non-bargaining-unit trainee rates receive a 4% adjustment increase and the base salary for each non-bargaining-unit employee who has 12 months of State service, or upon completing 12 months of State service, receives a 4% adjustment increase without change in the employee's creditable service date.

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

**Section 310.280 Designated Rate**

The rate of pay for a specific position or class of positions excluded from the other requirements of this Pay Plan shall be only as designated by the Governor.

**Department of Commerce & Economic Opportunity**

Private Secretary II
(Pos. No. 34202-42-00-000-01-02) 
**Annual Salary** $62,400

**Department of Healthcare and Family Services**
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Senior Public Service Administrator
(Pos. No. 40070-33-20-000-00-61)  
Annual Salary  
$123,060

Department of Human Services

Administrative Assistant I
(Pos. No. 00501-10-68-010-80-21)  
Annual Salary  
$55,200

Medical Administrator V
(Pos. No. 26406-10-76-000-00-01)  
Annual Salary  
$186,000

Department of Public Health

Senior Public Service Administrator
(Pos. No. 40070-20-80-000-00-81)  
Annual Salary  
$134,004

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

Section 310.290 Out-of-State or Foreign Service Rate

The out-of-state or foreign service rate is the rate of pay for employees occupying positions in these classification titles that require payment in accordance with the economic conditions and social legislation of another state or foreign country. The employee shall reside in the state or foreign country where the position is assigned. An adjustment shall be made once a month to the salary of an employee stationed in a foreign country to compensate for a change in the currency exchange rate.

The Director of Central Management Services will, before approving an adjustment, consider the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstances. Effective December 2, 2005, the base salary for each employee who has 12 months of State service, or upon completing 12 months of State service, receives a 4% adjustment increase without change in the employee's creditable service date. Effective July 1, 2003, adjustments, except those based on the currency exchange rate or those effective December 2, 2005, are suspended for non-union positions and employees.

For out-of-state rates, ranges assigned to states other than California and New Jersey are 15% above the ranges assigned to in-state positions and are listed in
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subsection (e). Ranges assigned to California and New Jersey are 30% above the ranges assigned to in-state positions and are listed in subsection (e).

d) For foreign service rates listed below, an adjustment shall be made once a month to the salary of an employee stationed in a foreign country to compensate for a change in the currency exchange rate.

e) Rates

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# DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PROPOSED AMENDMENTS

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

SUBPART C: MERIT COMPENSATION SYSTEM

Section 310.460 Other Pay Increases

a) Promotion – Normally upon promotion an employee shall be advanced in salary by an amount equivalent to between 8 and 15 percent of the current base salary. In no event is the resulting salary to be lower than the minimum rate of the salary range to which the employee is being promoted or greater than the maximum of the new salary range. Upon promotion the employee shall receive a new creditable service date.

b) Reallocation – Upon reallocation, an employee shall be advanced in salary to a rate of pay that is the equivalent of 5 percent above the current base salary. However, in no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the new salary range. A reallocation will not affect the creditable service date of the employee, unless an increase of 10% or greater is provided to move the employee to the minimum salary of the new title.

c) Reevaluation – If a higher salary range is assigned to a class, the employee occupying a position in the class normally shall be advanced the equivalent of 5 percent of the current base salary. However, in no event is the resulting salary to be lower than the minimum or higher than the maximum rate of the new salary range. The creditable service date of an employee will not be changed due to the reevaluation of the class the employee occupies, unless an increase of 10% or greater is provided to move the employee to the minimum salary of the new range.

d) Separation and Subsequent Appointment – Upon separation from a position of a given class and appointment within four calendar days to a position in a higher salary range, an increase shall be given under the conditions and requirements applicable to promotions, (see subsection paragraph (a)) above.

e) Reclassification – If the class to which the position is being moved has a higher salary range, the employee occupying the position shall be advanced the equivalent of 5 percent of the current base salary. However, in no event is the resulting salary to be lower than the minimum or higher than the maximum rate of
NOTICE OF PROPOSED AMENDMENTS

the new salary range. The creditable service date of the employee will not be changed due to the reclassification of the position the employee occupies, unless an increase of 10% or greater is provided to move the employee to the minimum salary of the new range.

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

Section 310.470 Adjustment

An employee may receive an upward adjustment in base salary for the purpose of correcting a previous error or oversight or, when the best interests of the agency and the State of Illinois will be served. Such adjustments must have the prior approval of the Director of Central Management Services. In determining the appropriateness of a request for a salary adjustment by an employing agency, the Director of Central Management Services will consider whether the need for the adjustment is substantial, whether the action is consistent with the treatment of other similar situations, and whether the action is equitable in view of the particular circumstances prompting the request. A salary adjustment of over 3% (unless the adjustment is effective December 2, 2005, or other adjustments result that results in $175 per month or less) will create a new creditable service date and require approval of the Governor's Office.

(Source: Amended at 30 Ill. Reg. ______, effective ____________)

Section 310.480 Decreases in Pay

Employees subject to this Part shall have their salaries reduced only as specified below. Any reduction in salary shall become effective on the first day of the month following approval of the reduction.

a) Demotion for Cause to a Lower Class – If the employee's current base salary is within the lower salary range, it shall be retained without change, but shall be reduced to the maximum of the lower salary range if in excess thereof. An employee demoted during a probationary period following promotion will have the base salary reduced to the same salary the employee received before being promoted and the previous creditable service date will be restored.

b) Position Reallocated to a Lower Class – If the employee's current base salary is within the lower salary range, it shall be retained without change, but shall be reduced to the maximum of the lower salary range if it excess thereof. However, as provided in Section 8(a) of the Personnel Code, the pay of an employee whose position is reallocated because of duties and responsibilities after appointment to
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such position shall not be required to be lowered to a salary within the range for a period of one year.

c) Voluntary Reduction to a Lower Class – If the employee's current base salary is within the lower salary range, it shall be retained without change, but shall be reduced to the maximum of the lower salary range if in excess thereof. However, an employee who voluntarily requests a reduction during a probationary period following a promotion will have the base salary reduced to the same salary in the lower salary range from which the employee was promoted and the previous creditable service date will be restored.

d) Assignment of a Lower Salary Range to a Class – If the employee's current base salary is within the lower salary range, it shall be retained without change, but shall be reduced to the maximum of the lower salary range if in excess thereof.

e) Adjustment – An employee may receive a downward adjustment in base salary for the purpose of correcting a previous error or oversight or when the best interest of the agency or the State of Illinois will be served. Adjustments must have the prior approval of the Director of Central Management Services in writing. In determining the appropriateness of a request for a salary adjustment by an employing agency, the Director of Central Management Services will consider whether the need for the adjustment is substantial, whether the action is consistent with the treatment of other similar situations, and whether the action is equitable in view of the particular circumstances prompting the request.

f) Reclassification – If the employee's current base salary is within the lower salary range, it shall be retained without change. If the employee's current base salary is higher than the maximum of the lower salary range, the base salary shall be reduced to the maximum of the lower salary range. As provided in Section 8(a) of the Personnel Code, the base salary shall not be lowered to a salary within the range for a period of one year.

(Source: Amended at 30 Ill. Reg. _______, effective ____________)

Section 310.490 Other Pay Provisions

a) Transfer – Upon assignment of an employee to a vacant position in a class with the same salary range as the class for the position being vacated, the employee's base salary will not be changed. Upon separation and subsequent appointment to a position in the same salary range, no increase in salary will be given.
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b) Entrance Salary – Normally upon entry to state service, an employee's base salary will be at the minimum salary of the salary range.

1) Qualifications above Minimum Requirements –

A) If a candidate possesses directly related training and experience in excess of the minimum requirements of the class specification, the employing agency may grant an entrance salary up to the midpoint of the first half of the salary range; however, this shall not provide more than a 10% increase over the candidate's current salary. Such qualifications above the minimum requirements must possess documented support for higher than the minimum entrance salary.

B) An entrance salary above the middle of the first half of the salary range must have prior approval of the Director of Central Management Services. This approval will be based on consideration of the candidate's training and experience exceeding the requirements of the class, prior salary history, particular staffing requirements of an agency, and labor market influence on recruitment needs.

2) Area Differential – For positions where additional compensation is required because of dissimilar economic or other conditions in the geographical area in which such positions are established, a higher entrance salary may be authorized by the Director of Central Management Services. Present employees receiving less than the new rate of pay shall be advanced to the new rate.

3) Upon the 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 the date of assignment.

c) Differential and Overtime Pay – An eligible employee may have an amount added to the base salary for a given pay period for work performed which is in excess of the normal requirements for the position and work schedule, as follows:

1) Shift Differential Pay – An employee may be paid an amount in addition
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to the 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 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.

2) Overtime Pay –

A) Eligibility — The Director of the Department of Central Management Services shall maintain a listing of classes of positions subject to the provisions of the Merit Compensation System that are eligible for overtime compensation. Classes in salary ranges MC 6 and below are eligible for straight-time overtime unless exceptions are determined by the Director of Central Management Services or federal guidelines. Employees in these classes of positions who are assigned and perform work in excess of the normal work schedule as established by the agency shall be compensated at a straight-time rate on either a cash or compensatory time-off basis for all hours worked in excess of a normal work week. Overtime in less than one-half hour increments per day shall not be accrued. Classes in MC 7 and above are not eligible for overtime unless required by federal regulation or approved by the Director of Central Management Services. Such exceptions must be requested by the employing agency and will be determined on the basis of the special nature of the situation, a substantial need to provide overtime compensation and a significant number of hours worked beyond the normal work schedule, and will be granted only for a specified time period for which the special situation is expected to exist.

B) Compensatory Time – 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. 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
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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.

d) Equivalent Earned Time –

| 1) Eligibility – Employees who are non-union, exempt under the Federal Fair Labor Standards Act, and in positions not eligible for overtime compensation may receive equivalent earned time for hours worked in excess of 40 actual work hours in a work week. |

| 2) Accrual – A) Employees who are eligible for equivalent earned time shall request such time before working in excess of 40 actual work hours in a work week. Requests for equivalent earned time may be granted by the agency at its discretion, considering its operating needs. Equivalent earned time shall be accrued at straight time only to a maximum of 120 hours in any fiscal year. B) Equivalent earned time will accrue in no less than one-half hour increments. Time spent in travel outside the normal work schedule shall not be counted toward accrual of equivalent earned time. |

| 3) Compensation – Any approved equivalent earned time shall be taken at a time convenient to the employee and consistent with the operating needs of the agency. Such time may not be carried over from one fiscal year to another fiscal year. At no time is equivalent earned time to be converted into cash payment or transferred from one agency to another agency. |

e) Part-Time Work – Part-time employees whose base salary is other than an hourly or daily basis shall be paid on a daily rate basis which will be computed from annual rates of salary and the total number of work days in the year.
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f) 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 circumstance.

g) 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 payments cannot be given in these transactions. Methods of computation are explained in Section 310.520(a) of the Merit Compensation System.

AGENCY NOTE: The method to be used in computing lump sum payment for vacation, sick leave* and unused compensatory overtime for an incumbent entitled to shift differential during the regular work hours will be to use the 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 sick days earned and retained during that time period.

h) Salary Treatment upon Return from Leave – An employee returning from Military Leave, Peace Corps Leave, Vista Leave, Service-Connected Disability Leave, Educational Leave, Disaster Services Leave with Pay, Family Responsibility Leave, Leave to accept a Temporary, Emergency, Provisional, Exempt or Trainee position, or Leave to serve in domestic peace or job corps or Education Leave will have his/her salary established as determined appropriate by the employing agency and approved by the Director of Central Management Services. However, in no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the salary range. Creditable service date will be maintained. An employee returning to his/her former salary range from any other leave of over fourteen days will be placed at the salary which the employee received prior to the leave and the creditable service date will be extended by the duration of the leave.

i) Employees in classes that are made subject to the Merit Compensation System after July 1, 1979, will retain their current salary, except that in no event
is the resultant salary to be lower than the minimum rate or higher than the maximum rate of the new salary range.

j) Extra Duty Pay – An employee may be paid an amount in addition to the base salary for services in addition to the regular work schedule on a special assignment. Additional compensation will be at a rate and manner 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.

k) Salary Treatment Upon Reemployment –

1) Upon the reemployment of an employee in a class with the same salary range as the class for the position held before layoff, the employee will be placed at the same salary as held at the time of the layoff, and his 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 same salary as held at the time of layoff, except that if this exceeds the maximum of the new range, the employee will be placed at that maximum salary. The creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.

l) Reinstatement – The salary upon reinstatement of an employee will be as determined by the employing agency and approved by the Director of Central Management Services. This salary should not provide more than a 10% increase over the candidate's current salary, or exceed the salary rate held in the position where previously certified. In no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the salary range.

m) Bilingual Pay – Individual positions whose job descriptions require the use of sign language, a second language, or 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.
ILLINOIS REGISTER

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n) Clothing or Equipment Allowance – An employee may be paid an amount in addition to his/her base salary to compensate for clothing or equipment which is required in the performance of assigned duties. The amount will be determined by the Director of the employing agency, and will require approval of the Director of the Department of Central Management Services. The Director of the Department 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 circumstance.

(Source: Amended at 30 Ill. Reg. _____, effective ____________)

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 of this Subpart.

"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 overtime pay or 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.

"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-grade or promotional salary increase. Reevaluations and reallocations will not affect the creditable service date. Adjustments (Section 310.470) "for the purpose of correcting a previous error or oversight" shall not result in a change in the creditable service date; however, adjustments in "the best interests of the agency" shall result in a new creditable service date unless the Director of the Department of Central Management Services determines such changes to be inequitable.
"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 Salary" – The initial base salary assigned to an employee upon entering State service.

"Interruption Merit Increase" – An intermittent merit increase is an increase in monthly base salary, other than the annual merit increase awarded to a merit compensation employee based on performance.

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

"Midpoint Salary" – The rate of pay that divides the rate range of a salary range into two equal parts.

"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.

"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 must 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.
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"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 approved by the Civil Service Commission.

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

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

"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 of the Department of Central Management Services.

(Source: Amended at 30 Ill. Reg. ______, effective ____________)
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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Section 310.APPENDIX A  Negotiated Rates of Pay

Section 310.TABLE L  RC-008 (Boilermakers)

Effective January 1, 2005

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<th>Monthly Salary</th>
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Effective September 2, 2005

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Effective January 1, 2006

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Northern Region: Boone, Cook, DeKalb, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will, and Winnebago Counties.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS


(Source: Amended at 30 Ill. Reg. ______, effective ____________)
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 310. APPENDIX A  Negotiated Rates of Pay

Section 310. TABLE T  HR-010 (Teachers of Deaf, IFT)

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Effective August 16, 2005

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NOTE: Effective the first day of the 1997 school year, the salary schedule will be adjusted by either $100 per month or 5% of the monthly salary, whichever is greater, for positions whose job descriptions require the use of sign language, or which require the employee to be bilingual.

Bilingual pay will be paid on a percentage scale based on the sign communication proficiency interview (SCPI) test. An employee would be paid the following percentage of the bilingual pay supplement based on the skill level on the SCPI test:

- 20% — Survival
- 40% — Survival Plus
- 60% — Intermediate
- 80% — Intermediate Plus
- 100% — Advanced

Effective January 1, 2006

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS

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NOTE: 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

Effective the first day of the 1997 school year, the salary schedule will be adjusted by either $100 per month or 5% of the monthly salary, whichever is greater, for positions whose job descriptions require the use of sign language, or which require the employee to be bilingual.

Bilingual pay will be paid on a percentage scale based on the SCPI test. An employee would be paid the following percentage of the bilingual pay supplement based on the skill level on the SCPI test:

20% Survival
40% Survival Plus
60% Intermediate
80% Intermediate Plus
100% Advanced

(Source: Amended at 30 Ill. Reg. ______, effective ____________)
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 310. APPENDIX A  Negotiated Rates of Pay

Section 310. TABLE U  HR-010 (Teachers of Deaf, Extracurricular Paid Activities)

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Extracurricular Activities Pay Schedule
Effective August 16, 2005

Classification I  Per Year

High School Head Coaches:
- Basketball – Boys  2907
- Basketball – Girls 2907
- Football  2907
- Track – Boys  2907
- Track – Girls  2907
- Volleyball  2907
- Wrestling  2907

Other Activities:
- Junior Class Sponsors  2907
- Senior Class Sponsors  2907

Classification II  Per Year

High School Assistant Coaches:
- Basketball – Boys  1835
- Basketball – Girls 1835
- Football  1835
- Track – Boys  1835
- Track – Girls  1835
- Volleyball  1835
- Wrestling  1835

Junior High School Head Coaches:
- 7th Grade Basketball – Boys  1835
**DEPARTMENT OF CENTRAL MANAGEMENT SERVICES**

**NOTICE OF PROPOSED AMENDMENTS**

8th Grade Basketball – Boys 1835
7th Grade Basketball – Girls 1835
8th Grade Basketball – Girls 1835
Track – Boys 1835
Track – Girls 1835
Volleyball 1835
Wrestling 1835
Football 1835

**Cheerleading Sponsor:**
High School Basketball 1835

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<tr>
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<td>Track – Girls</td>
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| **Scorekeepers and Timers** | **Per Event** |
**DEPARTMENT OF CENTRAL MANAGEMENT SERVICES**

**NOTICE OF PROPOSED AMENDMENTS**

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(Source: Amended at 30 Ill. Reg. ______, effective ____________ )
**NOTICE OF PROPOSED AMENDMENTS**

Section 310. APPENDIX B  Schedule of Salary Grades – Monthly Rates of Pay for Fiscal Year 2006

*Effective July 1, 2005*

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS

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(Source: Amended at 30 Ill. Reg. ______, effective __________)
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
NOTICE OF PROPOSED AMENDMENTS

**Section 310. APPENDIX C  Medical Administrator Rates for Fiscal Year 2006**

**Effective July 1, 2005**

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Effective December 2, 2005, the minimum, the base salary for each employee who has 12 months of State service, or upon completing 12 months of State service, receives a 4% adjustment increase without change in creditable service date.

**Effective December 2, 2005**

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The rates of pay for physicians occupying or appointed to a position in the Medical Administrator classes shall be as listed in the above schedule. All provisions of Subpart C of the Pay Plan, Merit Compensation System will apply to the Medical Administrator positions.

(Source: Amended at 30 Ill. Reg. ______, effective _____________)
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 310.APPENDIX D   Merit Compensation System Salary Schedule for Fiscal Year 2006

**Effective July 1, 2005**

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Effective December 2, 2005, the minimum, the base salary for each employee who has 12 months of State service, or upon completing 12 months of State service, receives a 4% adjustment increase without change in creditable service date.
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS

Effective December 2, 2005

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(Source: Amended at 30 Ill. Reg. ______, effective ____________)
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 310.APPENDIX G  Broad-Band Pay Range Classes Salary Schedule for Fiscal Year 2006

Effective July 1, 2005

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Effective December 2, 2005, the minimum, the base salary for each employee who has 12 months of State service, or upon completing 12 months of State service, receives a 4% adjustment increase without change in creditable service date.

Effective December 2, 2005

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(Source: Amended at 30 Ill. Reg. ______, effective ____________)
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) **Heading of the Part:** Illinois Cares Rx Program

2) **Code Citation:** 89 Ill. Adm. Code 119

3) **Section Numbers:**

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<td>119.140</td>
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4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 94-86

5) **Complete Description of the Subjects and Issues Involved:** These proposed amendments respond to Public Act 94-86 under which the Illinois Cares Rx Program is being established. This new program provides pharmaceutical assistance to eligible seniors and individuals with disabilities and will provide coverage for specified prescription drugs. The program provides benefits for individuals who are eligible for Medicare Part D and drug coverage for those who are not eligible for Medicare Part D. Illinois Cares Rx replaces SeniorCare and Circuit Breaker Pharmaceutical Assistance. Absent Illinois Cares Rx, eligible individuals would be responsible for significantly higher levels of cost-sharing than they had previously experienced under Circuit Breaker and SeniorCare.

The transition of seniors to Medicare Part D and Illinois Cares Rx is expected to result in a total savings of approximately $26.3 million.

6) **Will this rulemaking replace any emergency amendments currently in effect?** No

7) **Does this rulemaking contain an automatic repeal date?** No
NOTICE OF PROPOSED AMENDMENTS

8) Does this rulemaking contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

11) 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:

   Joanne Scattoloni  
   Office of the General Counsel, Rules Section  
   Illinois Department of Healthcare and Family Services  
   201 South Grand Avenue East, Third Floor  
   Springfield, Illinois 62763-0002  

   (217)524-0081

   The Department requests the submission of written comments within 30 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].

12) Initial Regulatory Flexibility Analysis:

   A) Types of small businesses, small municipalities and not-for-profit corporations affected: Pharmacies

   B) Reporting, bookkeeping or other procedures required for compliance: None

   C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on Which this Rulemaking Was Summarized: These proposed amendments were not included on either of the two most recent agendas because: This rulemaking was not anticipated by the Department when the two most recent regulatory agendas were published.

   The full text of the Proposed Amendments is identical to the text of the Emergency Amendments
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that appears in this issue of the Illinois Register on page 482:
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NOTICE OF PROPOSED REPEALER

1) **Heading of the Part:** Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act

2) **Code Citation:** 89 Ill. Adm. Code 126

3) **Section Numbers:**

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4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Executive Order 2004-3

5) **Complete Description of the Subjects and Issues Involved:** These rules pertain to the Pharmaceutical Assistance Program, which was initially administered by the Department of Revenue, and then transferred to the Department of Public Aid under Executive Order 2004-3, effective July 1, 2004. The Department subsequently adopted new administrative rules for operation of the Program, at 89 Ill. Adm. Code 119, on February
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25, 2005 (published at 29 Ill. Reg. 4069 on March 11, 2005). The Department of Revenue's rules (86 Ill. Adm. Code 530) were transferred to the Department (89 Ill. Adm. Code 126), but Part 126 is obsolete due to the adoption of Part 119. Therefore, Part 126 is being proposed for repeal.

6) Will this proposed repealer replace any emergency amendments currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed repealer contain incorporations by reference? No

9) Are there any proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This proposed repealer does not affect units of local government.

11) 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:

   Joanne Scattoloni
   Office of the General Counsel, Rules Section
   Illinois Department of Public Aid
   201 South Grand Avenue East, Third Floor
   Springfield, Illinois 62763-0002

   (217)524-0081

   The Department requests the submission of written comments within 30 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].

12) 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
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C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on Which this Rulemaking Was Summarized: This proposed repealer was not included on either of the two most recent regulatory agendas because: This rulemaking was not anticipated by the Department when the most recent regulatory agendas were published.

The full text of the Proposed Repealer begins on the next page:
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NOTICE OF PROPOSED REPEALER

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 126
SENIOR CITIZENS AND DISABLED PERSONS PROPERTY TAX RELIEF AND PHARMACEUTICAL ASSISTANCE ACT (REPEALED)

SUBPART A: SENIOR CITIZENS AND DISABLED PERSONS PROPERTY TAX RELIEF AND PHARMACEUTICAL ASSISTANCE ACT

Section
126.101 Purpose of the Pharmaceutical Assistance Program
126.105 Definitions
126.110 Covered Prescription Drugs
126.116 Fees and Co-payments
126.125 Determination of Cost of Covered Prescription Drugs
126.130 Authorized Pharmacy Qualifications
126.135 Assignment and Coordination of Benefits
126.140 Payments to Authorized Pharmacies
126.145 Execution of Contracts
126.150 Limitation on Prescription Size
126.155 Inspection and Disclosure of Records
126.160 Establishment of Liens
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SUBPART B: SENIOR CITIZENS AND DISABLED PERSONS PRESCRIPTION DRUG DISCOUNT PROGRAM

Section
126.200 Purpose
126.205 Definitions
126.210 Eligibility
126.215 Enrollment Fee
126.220 Other Administrative Responsibilities of the Department
126.225 Eligibility Determination
126.230 Enrollment
126.235 Re-enrollment
126.240 Other Administrative Responsibilities
126.245 Termination of Program Administrator
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126.250 Senior Citizens and Disabled Persons Prescription Drug Discount Program Fund
126.255 Discounts


SUBPART A: SENIOR CITIZENS AND DISABLED PERSONS PROPERTY TAX RELIEF AND PHARMACEUTICAL ASSISTANCE ACT

Section 126.101 Purpose of the Pharmaceutical Assistance Program

The Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act (Act) [320 ILCS 25] provides for the establishment of a program of pharmaceutical assistance to be administered by the Illinois Department of Revenue. Executive Order 2004-3 transfers this program to the Department on Aging and the Department of Public Aid, effective July 1, 2004. The purpose for this program is to enable low-income senior citizens and disabled persons to afford medication for the treatment of heart disease and its related conditions, diabetes, arthritis; and, beginning January 1, 2001, cancer, Alzheimer's disease, Parkinson's disease, glaucoma, lung disease and smoking related illnesses; and, beginning July 1, 2001, osteoporosis; and, beginning January 1, 2004, multiple sclerosis.

Section 126.105 Definitions
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The following definitions apply to the terms used in this Subpart A:

"Act" means the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act [320 ILCS 25].

"Additional resident" means any person who is not filing a separate claim for the same claim year under this Act and who is living in the same residence with a claimant and for whom the household has provided more than half of that person's total financial support for a claim year.

"Applicant" means a claimant, any person in a household who has requested pharmaceutical assistance benefits on a claim filed by a claimant and, beginning January 1, 2001, any additional resident who would become a beneficiary if the claim is approved by the Department on Aging.

"Beneficiary" means a person whose claim for pharmaceutical assistance benefits under the Act has been approved by the Department on Aging.

"Card" means an identification card issued to a beneficiary by the Department of Revenue prior to January 1, 2001, and a Pharmaceutical Assistance Card issued to a beneficiary by the Department of Revenue or the Department on Aging on and after January 1, 2001.

"Claim" means an original paper application (IDOR Form No. IL-1363, possibly using Schedule A, Schedule B, and/or Schedule P), an amended paper application (IDOR Form No. IL-1363-X), or an electronic application filed by a verified Internet Filer for pharmaceutical assistance benefits under the Act.

"Claimant" means a person who has filed a claim for pharmaceutical assistance benefits under the Act. [320 ILCS 25/3.01]

"Claim year" means the calendar year prior to the year in which an applicant files a claim for pharmaceutical assistance benefits.

"Coverage year" means the period of time during which a beneficiary receives pharmaceutical assistance benefits for a claim year.

"Covered prescription drug" means any drug included in the categories listed in Section 126.110 for which the Department on Aging approves a claim for
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pharmaceutical assistance benefits.

"Current income" means household income for a claim year unless an applicant requests and is allowed by the Department on Aging to use projected income for a coverage year.

"Department" means the Illinois Department of Public Aid. [320 ILCS 25/3.02]

"Director" means the Director of the Illinois Department of Public Aid. [320 ILCS 25/3.03]

"Disabled person" means a person who is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. [320 ILCS 25/3.14]

"Disease" means a chronic and possibly recurrent illness of long duration, as distinguished from an acute illness that is of short duration with recovery due to limited medical treatment (such as in the case of colds, flu, pneumonia, bronchitis, or other similar illnesses).

"Household" means a claimant or a claimant and his or her spouse living together in the same residence. [320 ILCS 25/3.05]

"Household income" means the combined income of the members of a household for a claim year. [320 ILCS 25/3.06]

"Program" means the Pharmaceutical Assistance Program provided for under the Act.

"Projected income" means household income expected to be received for a coverage year.

Section 126.110 Covered Prescription Drugs

a) Drugs, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60], physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987 [225 ILCS 95], or advanced practice nurse licensed pursuant to Title 15 of the Nursing and
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Advanced Practice Nursing Act [225 ILCS 65/Title 15] for treatment of heart disease and its related conditions, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Antihypertensive
2) Antianginal
3) Antiarrhythmic
4) Antihyperlipidemic
5) Beta Blocker
6) Digitalis Glycosides
7) Hypertension/Shock
8) Diuretics
9) Potassium
10) Anticoagulants

b) Drugs purchased on or after January 1, 1987, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987, physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of diabetes, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Insulin
2) Insulin, Syringes & Needles
3) Oral Hypoglycemics
4) Pituitary Hormones
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5) Glucose Elevators

c) Drugs purchased on or after January 1, 1987, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987, physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of arthritis, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Hormones/Adrenal Cortical Steroids
2) Analgesics/Antirheumatic
3) Analgesics/Nonopiate Agonists
4) Antiprotozoals
5) Penicillamine
6) Analgesics/Narcotic Antagonists: Gout
7) Oncolytic/Antineoplastic: Antimetabolites
8) Immunosuppressives

d) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987, physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of cancer, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Alkylating Agents
2) Antimetabolites
3) Antimitotic Agents
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4) Epipodophyllotoxins
5) Antibiotics
6) Hormones
7) Enzymes
8) Platinum Coordination Complex
9) Anthracenedione
10) Substituted Ureas
11) Methylhydrazine Derivatives
12) Cytoprotective Agents
13) DNA Topoisomerase Inhibitors
14) Biological Response Modifiers
15) Retinoids
16) Monoclonal Antibodies
17) Miscellaneous Antineoplasticstics
18) Narcotic Agonist Analgesics
19) Narcotic Analgesic Combinations
20) Anticonvulsants

e) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987, physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of Alzheimer's disease, qualify for inclusion in the
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Pharmaceutical Assistance Program as covered prescription drugs:

1) Cholinesterase Inhibitors

2) Antipsychotics

f) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987, physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of Parkinson's disease, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Anticholinergics

2) Amantadine

3) Bromocriptine Mesylate

4) Carbidopa

5) Levodopa

6) Levodopa and Carbidopa

7) Pergolide Mesylate

8) Selegiline Hydrochloride

9) Entacapone

10) Tolcapone

11) Dopaminergics

12) Clonazepam

g) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of
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its branches pursuant to the Medical Practice Act of 1987, therapeutically certified optometrist licensed pursuant to the Illinois Optometric Practice Act of 1987 [225 ILCS 80/15.1], physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of glaucoma, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Alpha-2 Adrenergic Agonists
2) Sympathomimetics
3) Alppha-Adrenergic Blocking Agents
4) Beta-Adrenergic Blocking Agents
5) Miotics, Direct Acting
6) Miotics, Cholinesterase Inhibitors
7) Carbonic Anhydrase Inhibitors
8) Prostaglandin Agonists
9) Miscellaneous Combinations

h) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987, physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of lung disease and smoking related illnesses, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Sympathomimetic Bronchodilators
2) Diluents
3) Xanthine Derivatives
4) Anticholinergic Bronchodilators
5) Leukotriene Receptor Antagonists
6) Leukotriene Formation Inhibitors
7) Corticosteroid Respiratory Inhalants
8) Mucolytics
9) Mast Cell Stabilizers
10) Respiratory Enzymes
11) Digestive Enzymes
12) Antiasthmatic Combinations
13) Antituberculosal Agents
14) Zyban
15) Nicotine

i) Drugs purchased on or after July 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987, physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of osteoporosis, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Bisphosphonates
2) Selective Estrogen Receptor Modulators
3) Calcitonin-Salmon

j) Drugs purchased on or after January 1, 2004 that fall within the following
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categories and are prescribed by a physician licensed to practice medicine in all of
its branches pursuant to the Medical Practice Act of 1987, physician assistant
licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced
practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice
Nursing Act for the treatment of multiple sclerosis, qualify for inclusion in the
Pharmaceutical Assistance Program as covered prescription drugs:

1) Corticosteroids

2) Immunomodulatory Agents (including Interferon Beta – 1a and Interferon
Beta – 1b)

3) Immunosuppressants

4) Antineoplastics

k) A covered prescription drug must be approved by the Food and Drug
Administration of the federal Department of Health and Human Services for the
treatment of a specific disease category.

l) The specific covered prescription drugs which fall within each category will be
listed in a handbook to be prepared and disseminated on the internet Web site of
the Department. Updates regarding changes in the categories and specific
covered prescription drugs will be made as necessary.

Section 126.116 Fees and Co-payments

a) Fees

1) An applicant must pay a fee to the Department on Aging effective July 1,
2004 or the Department of Revenue before that date for a card as follows:

A) Prior to January 1, 2001, an applicant must pay $40 for a card if
his or her household income for a claim year is below the poverty
line.

B) Prior to January 1, 2001, an applicant must pay $80 for a card if
his or her household income for a claim year is at or above the
poverty line.
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C)  Beginning January 1, 2001, an applicant must pay $5 for a card if his or her household income for a claim year is below the poverty line.

D)  Beginning January 1, 2001, an applicant must pay $25 for a card if his or her household income for a claim year is at or above the poverty line. [320 ILCS 25/4(f)]

2)  The term "poverty line" means the official poverty line as defined by the Federal Office of Management and Budget at 42 USC 9902(2).

3)  Fees paid for cards will not be prorated if coverage is valid for a longer or shorter period than one year as determined by the Department on Aging in converting coverage to a fiscal year basis.

b)  Covered Prescription Drug Co-payments

1)  A beneficiary must make co-payments to an authorized pharmacy for covered prescription drugs as follows:

A)  A beneficiary who pays $40 for a card must pay a deductible equal to the first $15 of total prescription costs each month until the accumulated total paid by this program reaches $800 for a State fiscal year prior to the 2001 State fiscal year. For the portion of the 2001 State fiscal year from July 1, 2000 through December 31, 2000, after the accumulated total of $800 has been reached, the beneficiary must pay the first $15 of total prescription costs each month plus a co-payment equal to 20% of the cost of each prescription for which payments are made by this program. For the portion of the 2001 State fiscal year from January 1, 2001 through June 30, 2001, after the accumulated total of $2,000 (which includes the accumulated total of $800 or less for the period from July 1, 2000 through December 31, 2000) for the entire 2001 State fiscal year has been reached, the beneficiary must pay a co-payment equal to 20% of the cost of each prescription for which payments are made by this program for the remainder of the State fiscal year. For all subsequent State fiscal years after the 2001 State fiscal year, after the accumulated total of $2,000 for the State fiscal year has been reached, the beneficiary must pay a co-payment equal to 20% of the cost of
B) A beneficiary who pays $80 for a card must pay a deductible equal to the first $25 of total prescription costs each month until the accumulated total paid by this program reaches $800 for a State fiscal year prior to the 2001 State fiscal year. For the portion of the 2001 State fiscal year from July 1, 2000 through December 31, 2000, after the accumulated total of $800 has been reached, the beneficiary must pay the first $25 of total prescription costs each month plus a co-payment equal to 20% of the cost of each prescription for which payments are made by this program. For the portion of the 2001 State fiscal year from January 1, 2001 through June 30, 2001, after the accumulated total of $2,000 (which includes the accumulated total of $800 or less for the period from July 1, 2000 through December 31, 2000) for the entire 2001 State fiscal year has been reached, the beneficiary must pay $3 for each prescription plus a co-payment equal to 20% of the cost of each prescription for which payments are made by this program for the remainder of the State fiscal year. For all subsequent State fiscal years after the 2001 State fiscal year, after the accumulated total of $2,000 for the State fiscal year has been reached, the beneficiary must pay $3 for each prescription plus a co-payment equal to 20% of the cost of each prescription for which payments are made by this program for the remainder of the State fiscal year. [320 ILCS 25/4(f)]

C) Beginning with the portion of the 2001 State fiscal year from January 1, 2001 through June 30, 2001, and for all subsequent State fiscal years, a beneficiary who pays $5 for a card will pay no additional prescription costs until the accumulated total paid by this program reaches $2,000 for the State fiscal year, at which point the beneficiary must pay a co-payment equal to 20% of the cost of each prescription paid by this program for the remainder of the State fiscal year.

D) Beginning with the portion of the 2001 State fiscal year from January 1, 2001 through June 30, 2001, and for all subsequent State fiscal years, a beneficiary who pays $25 for a card must pay $3 for each prescription until the accumulated total paid by this
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program reaches $2,000 for the State fiscal year, at which point the beneficiary must continue to pay $3 for each prescription plus a co-payment equal to 20% of the cost of each prescription paid by this program for the remainder of the State fiscal year. [320 ILCS 25/4(f)]

2) A beneficiary also must pay to an authorized pharmacy an ancillary charge for any covered prescription drug that is a brand name product if the pharmacy is reimbursed at the generic price as provided in Section 126.125(d)(2).

Section 126.125 Determination of Cost of Covered Prescription Drugs

a) The Department will pay an authorized pharmacy the reasonable cost of pharmaceutical services that such pharmacy provided to a beneficiary pursuant to a physician's oral or written prescription authorization.

b) Determination of Reasonable Cost. For contracts executed and in effect on or after July 1, 2002, as subject to periodic review, the Department will determine the rate for the reasonable cost of covered prescription drugs for which payment will be made to an authorized pharmacy in an amount equal to:

1) the lesser of:

   A) the Average Wholesale Price (AWP) for the covered prescription drug minus 14%, based on the National Drug Code (NDC) number for the original package size from which such drug was dispensed (AWP is determined by the most current information provided by drug pricing services such as First DataBank or other source nationally recognized in the retail prescription drug industry selected by the Department's claims processing vendor); or

   B) the Maximum Allowable Cost (MAC) for the covered prescription drug, based on the MAC list for this program (MAC is determined by the Department's claims processing vendor); or

   C) the usual and customary cost for the covered prescription drug; plus

2) the professional dispensing fee; less
3) any applicable co-payments, deductibles, and ancillary charges.

c) Professional Dispensing Fee. For contracts executed and in effect on or after July 1, 2002, as subject to periodic review, the Department shall determine the professional dispensing fee to be charged by authorized pharmacies. The professional dispensing fee shall be in the amount of $2.55 per prescription.

d) Payment.

1) Payment to authorized pharmacies will be allowed for covered prescription drugs legally marketed in accordance with the rules and regulations of the Food and Drug Administration of the federal Department of Health and Human Services.

2) Payment will be at the generic price as provided in subsection (b) unless the following conditions exist:

A) an oral prescription is filled, refilled, or renewed for a covered prescription drug that is a brand name product for which no generic equivalent is available; or

B) a written prescription is filled, refilled, or renewed for a covered prescription drug that is a brand name product for which no generic equivalent is available; or

C) beginning January 1, 2001, an oral prescription is filled, refilled, or renewed for a covered prescription drug that is a brand name product containing one or more ingredients defined as a narrow therapeutic index drug at 21 CFR 320.33 and the prescriber stipulates "brand medically necessary" and that substitution is not permitted; or

D) beginning January 1, 2001, a written prescription is filled, refilled, or renewed for a covered prescription drug that is a brand name product containing one or more ingredients defined as a narrow therapeutic index drug at 21 CFR 320.33 and indicates on its face "brand medically necessary" and that substitution is not permitted.

e) Pharmacy's Cost of On-line Communications. Each authorized pharmacy
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participating in this program shall pay all costs, charges and fees incurred by the pharmacy that are related to on-line communication and the processing of claims or other information sent to or from the Department or the Department's claims processing vendor.

f) The reasonable cost of covered prescription drugs available to beneficiaries in this program shall not exceed the cost of such drugs when dispensed to the general public.

g) In the event that generic equivalents for covered prescription drugs are available at lower cost, the Department shall establish the maximum allowable cost for such covered prescription drugs at the lower generic cost as provided in subsection (b).

Section 126.130 Authorized Pharmacy Qualifications

Only pharmacies that are registered in Illinois under the Pharmacy Practice Act of 1987 [225 ILCS 85] are authorized pharmacies eligible to participate in this program. [320 ILCS 25/6(d)]

Section 126.135 Assignment and Coordination of Benefits

a) Where a beneficiary is entitled to benefits from any private plan of assistance, including any insurance plan, public assistance program, or third party for covered prescription drugs under this program, he or she must execute an assignment of those benefits to the Department. [320 ILCS 25/6(d)(4)]

b) The Department shall charge or collect payments from any private plan of assistance, including any insurance plan, public assistance program, or third party for any claims assigned by a beneficiary. (See 320 ILCS 25/4(f) and 6(d.).)

Section 126.140 Payments to Authorized Pharmacies

Payments to authorized pharmacies under the Act shall be made in accordance with the State Prompt Payment Act [30 ILCS 540]. [320 ILCS 25/6(d)(7)]

Section 126.145 Execution of Contracts

a) The Director or his or her designee has the authority to enter into written contracts with any State agency, instrumentally or political subdivision, or a fiscal intermediary for the purpose of making payments to authorized pharmacies who participate in this program and coordinating this program with other public
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assistance programs. (See 320 ILCS 25/6(d).)

b) Contracts entered into by or on behalf of the Department and authorized pharmacies shall stipulate the terms and conditions for participation in this program and the right of the Department to terminate participation for breach of contract or violation of federal or State law. [320 ILCS 25/6(d)(1)]

Section 126.150 Limitation on Prescription Size

An authorized pharmacy may not provide a beneficiary with more than a 34-day supply of any covered prescription drug in filling, refilling, or renewing a prescription, except as otherwise specified for medical or utilization control reasons in the handbook prepared and disseminated on the internet Web site of the Department. [350 ILCS 25/6(d)(2)] Such an exception is specified in the handbook for covered prescription drugs classified as maintenance drugs which are less expensive to dispense in greater quantities due to larger daily dose requirement.

Section 126.155 Inspection and Disclosure of Records

a) In order to ensure compliance with the requirements of the Act and to prevent fraud, the Department, or its designee, shall have the right:

1) to inspect the books and records of all authorized pharmacies. [320 ILCS 25/6(d)(5)]

2) to require disclosure of information on individuals who receive health coverage, pharmaceutical benefits, or related services as policyholders, subscribers, or plan participants from entities subject to the Illinois Insurance Code [215 ILCS 5], Comprehensive Health Insurance Plan Act [215 ILCS 105], Dental Service Plan Act [225 ILCS 25], Children’s Health Insurance Program Act [215 ILCS 106], Health Care Purchasing Group Act [215 ILCS 123], Health Maintenance Organization Act [215 ILCS 125], Limited Health Service Organization Act [215 ILCS 130], Voluntary Health Services Plans Act [215 ILCS 165], and Worker’s Compensation Act [820 ILCS 305]. (See 320 ILCS 25/4.1.)

b) Information received by the Department or its designee shall be confidential except for official purposes and as otherwise provided in the Act.

Section 126.160 Establishment of Liens
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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The Director is entitled to establish a lien on any and all causes of action which accrue to a beneficiary as a result of injuries for which covered prescription drugs are directly or indirectly prescribed and for which payment was made under this program. [320 ILCS 25/6(d)(3)]

Section 126.165 Penalties

a) Any person who:

1) for compensation prepares a claim for this program and knowingly enters false information on the claim for an applicant or a beneficiary; or

2) fraudulently files multiple claims; or

3) on behalf of an authorized pharmacy, files a fraudulent claim for payment; or

4) fraudulently states that a nondisabled person is disabled; or

5) fraudulently procures a card; or

6) fraudulently uses card to obtain covered prescription drugs

is guilty of a Class 4 felony for the first offense and a Class 3 felony for each subsequent offense. [320 ILCS 25/9]

b) The Department will recover from any beneficiary or authorized pharmacy any amount paid under this program on account of an erroneous or fraudulent claim, together with 6 percent interest per year. [320 ILCS 25/9]

c) A prosecution for violation of the provisions of the Act may be undertaken at any time within three years after the commission of that violation. [320 ILCS 25/9]

SUBPART B: SENIOR CITIZENS AND DISABLED PERSONS PRESCRIPTION DRUG DISCOUNT PROGRAM

Section 126.200 Purpose

This Part implements the Senior Citizens and Disabled Persons Prescription Drug Discount Program, also known as the Illinois Rx Buying Club, to enable Illinois senior citizens and disabled persons to purchase prescription drugs at discounted prices.
Section 126.205 Definitions

The following terms have the following meanings:

"Act" means the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act [320 ILCS 55].

"Authorized Pharmacy" means any pharmacy registered in this State under the Pharmacy Practice Act of 1987 and approved by the Department or its Program Administrator.

"AWP" or "Average Wholesale Price" means the amount determined from the latest publication of the Red Book, a universally subscribed pharmacist reference guide published by the Hearst Corporation. AWP may also be derived electronically from the drug pricing database synonymous with the latest publication of the Red Book and furnished in the National Drug Data File (NDDF) by First DataBank (FDB), a service of the Hearst Corporation.

"Cardholder" means an eligible senior or eligible disabled person who has enrolled in the program.

"Citizen" means a resident of the State of Illinois.

"Department" or "HFS" means the Department of Healthcare and Family Services.

"Director" means the Director of the Department of Healthcare and Family Services.

"Drug Manufacturer" means any entity that is located within or outside Illinois that is engaged in:

the production, preparation, propagation, compounding, conversion, or processing of prescription drug products covered under the program, either directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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the packaging, repackaging, leveling, labeling, or distribution of
prescription drug products covered under the program

and that elects to provide prescription drugs either directly or under contract with any entity providing prescription drug services on behalf of the State of Illinois. Drug manufacturer, however, does not include a wholesale distributor of drugs or a retail pharmacy licensed under Illinois law.

"Eligible Disabled Person" means a resident of Illinois who is disabled under a Class 2 disability as defined in Section 4A of the Illinois Identification Card Act [15 ILCS 335] or is eligible to receive disability under the Federal Social Security Act.

"Eligible Enrollee" means an eligible senior and/or eligible disabled person.

"Eligible Senior" means a resident of Illinois who is 65 years of age or older.

"Participating Pharmacy" means a pharmacy that has entered into a contract with the Program Administrator to participate in this program.

"Prescription Drug" means any prescribed drug that may be legally dispensed by an authorized pharmacy.

"Program" means the Illinois Rx Buying Club created under the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act.

"Program Administrator" means the entity that is chosen by the Department to administer the program, consistent with the requirements of the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act and this Part.

"Program Fund" means the Senior Citizens and Disabled Persons Prescription Drug Discount Program Fund, created as a special fund under the State Finance Act [30 ILCS 105/5.595].

Section 2151.210  Eligibility

Eligibility is limited to residents of Illinois who are:
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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a) Disabled and under a Class 2 disability as defined in Section 4A of the Illinois Identification Card Act [15 ILCS 335/4A] and/or is eligible to receive disability under the Federal Social Security Act; or

b) 65 years of age and older; or

c) Eligible for pharmaceutical assistance under the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act (PAP).

Section 126.215 Enrollment Fee

To participate in the program, an approved applicant must pay $10 upon enrollment and annually thereafter (Section 35(a) of the Act). The enrollment fee for persons eligible through PAP is waived (Section 35(c) of the Act). The Director may, by rule, reduce the annual enrollment fee, based upon actual administrative costs. The Department shall establish, maintain and account for annual enrollment fees in the Senior Citizens and Disabled Persons Prescription Drug Fund.

Section 126.220 Other Administrative Responsibilities of the Department

a) In discharging its administrative responsibilities pursuant to the Act, the Department will either act as the Program Administrator or enter into a contract with an outside vendor, pursuant to Section 25 of the Act, and/or agreements with State agencies under which those entities will serve as the Program administrator and/or exercise various recordkeeping and other administrative functions. Any contract or agreement must provide for inspection of appropriate records and audits of participating pharmacies or other appropriate measures deemed sufficient by the Director, in his or her discretion, to ensure contract compliance and to determine any fraudulent transactions or practices under the Act. Any contract entered into with outside vendors must be in compliance with the procedures and requirements set forth in the Illinois Procurement Code [30 ILCS 500] and 40 Ill. Adm. Code 1.

b) The Department will reimburse the Program Administrator for the cost of cardholder enrollment, pursuant to the contract entered into by the Department and the Program Administrator. The amount of reimbursement, not to exceed $10, will be at a rate to be agreed upon by the Department and the Program Administrator and will be set forth in the contract.
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c) The Department will, in cooperation with the Program Administrator, establish procedures for properly contracting for pharmacy services and validating compliance of authorized pharmacies with the Act and this Part.

d) The Department shall report to the Governor and the General Assembly by March 1 of each year on the administration of the program.

Section 126.225 Eligibility Determination

The Program Administrator shall obtain the necessary enrollment information from applicants and shall verify eligibility. Eligibility shall be determined within 30 days after receipt of the application.

Section 126.230 Enrollment

The Program Administrator shall:

a) Enroll eligible applicants into the program.

1) Enrollment of PAP members is automatic.

2) Other eligible applicants may enroll by mail, facsimile or telephonic process.

3) Eligible applicants who enroll by mail or facsimile shall apply on the form prescribed by the Department, which shall include, but not be limited to, the following elements:

   A) complete name, mailing address, telephone number;

   B) Social Security number;

   C) payment provisions;

   D) applicant certification;

   E) age and disability status;

   F) participation requirements for other programs;
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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G) certification of information provided; and

H) Program Administrator and/or agency contact information.

Also included will be a recital that only one pharmaceutical card may be used to purchase a prescription.

b) Distribute the identification card to the eligible enrollee.

c) Enroll persons participating in PAP, through an electronic file provided by the Department of Revenue or any subsequent State agency responsible for the administration of PAP.

d) Collect and deposit enrollment fees into the Senior Citizens and Disabled Persons Prescription Drug Discount Program Fund.

Section 126.235 Re-enrollment

a) The period of enrollment in the program is one year. Cardholders must re-enroll each year by their one-year anniversary date or enrollment is terminated.

b) Any person eligible for PAP is automatically enrolled in the program and is not required to re-enroll annually. Enrollment of these persons is automatically terminated if the person is no longer eligible under PAP.

Section 126.240 Other Administrative Responsibilities

a) The Program Administrator shall contract with pharmacies electing to participate in the Illinois Rx Buying Club.

b) Contracts with pharmacies shall require that a participating pharmacy, at a minimum, shall be licensed in Illinois.

c) The discounts to a card shall be no less than, but may be greater than:

1) AWP minus 12% for brand name drug products and, for a period of 6 months following release, newly release generic drug products; and

2) AWP minus 35% for all other generic drug products.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED REPEALER

d) The dispensing fees shall be no greater than, but may be less than:

1) $3.50 per prescription for brand name drug products, single-source drug products, and, for a period of 6 months after their release, newly released generic drug products; and

2) $4.25 per prescription for all other generic drug products.

e) Cardholders may purchase medications in amounts up to a 90-day supply, except as may be necessary for utilization control reasons.

f) The Department and/or Program Administrator may negotiate with one or more drug manufacturers for payment rebates. These rebate dollars are to be used to further reduce the prescription cost to seniors and disabled persons, consistent with the requirements of the Act and this Part.

g) Subject to funds available through rebate agreements negotiated by the Department or the Program Administrator and drug manufacturers, a participating pharmacy shall be reimbursed any difference between the contracted discount rate agreed to by the participating pharmacy and the actual amount paid by the cardholder. Nothing in this subsection precludes a participating pharmacy from knowingly and voluntarily accepting a contract rate that provides the eligible cardholder with lower out-of-pocket costs than those set forth in the Act. All discounts negotiated with a participating pharmacy greater than the minimum discount set forth in subsection (c) shall be given, in its entirety, directly to the cardholder at the point of sale.

h) The Program Administrator is responsible for providing reports to the Department regarding enrollment participation, prescription costs, savings, pharmacy participation, and any other reports deemed necessary by the Department. The format of the reports shall be mutually agreed upon by the Program Administrator and the Department. The Administrator's provision of such reports shall not preclude the Department from inspection of appropriate records and audits of pharmacies pursuant to Section 45(3) of the Act.

i) The Program Administrator is responsible for providing customer service to cardholders and is responsible for developing, administering and promoting any clinical programs, such as disease management, implemented at the discretion of the Director.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED REPEALER

Section 126.245 Termination of Program Administrator

a) The contract with the Program Administrator may be terminated by the Director, with cause, upon 30 days written notice or, without cause, upon at least 120 days written notice. Reasons for cause include, but are not limited to, gross and/or repeated negligence of the Program Administrator and failure of the Program Administrator to meet substantially and/or consistently the standards of performance.

b) Upon written notice, the Director may require the Program Administrator to modify its conduct of the Program.

Section 126.250 Senior Citizens and Disabled Persons Prescription Drug Discount Program Fund

The Department and/or Program Administrator shall collect and the Department shall deposit enrollment fees into the Senior Citizens and Disabled Persons Prescription Drug Discount Program Fund. The Department shall separately account for enrollment fees deposited into the Fund.

Section 126.255 Discounts

a) The Program Administrator shall electronically communicate prescription drug discount information to the participating pharmacy.

b) The Program Administrator shall ensure and guarantee that a cardholder will be charged no more than the rate agreed to in the contract.

c) Any manufacturer or group purchasing organization rebate used to provide a discount greater than the agreed to pharmacy rate to the cardholder shall be reimbursed to the participating pharmacy subject to availability of funds.

d) The cardholder shall receive the greatest discount available through the participating pharmacy at the point of sale. The total amount paid by the available cardholder for any prescription drug under this program shall not exceed the usual and customary charge for the prescription.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED RULES

1) **Heading of the Part**: The Illinois Prescription Drug Discount Program

2) **Code Citation**: 89 Ill. Adm. Code 126

3) **Section Numbers**

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4) **Statutory Authority**: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 94-86

5) **Complete Description of the Subjects and Issues Involved**: These proposed amendments respond to Public Act 94-86 under which the Illinois Prescription Drug Discount Program is established, effective January 1, 2006. This new program, also known as the Illinois Rx Buying Club, will enable eligible Illinois residents to purchase prescription drugs at discounted prices. Illinois residents with household incomes that are equal to or less than 300 percent of the Federal Poverty Level are eligible for the new program. An annual enrollment fee will be required from all participants in the program. Authorized pharmacies that participate in the program shall enter into a contract with the Program Administrator. The program allows for negotiation with drug manufacturers for payment rebates. It is expected that price reductions on prescription drugs will benefit the health and well-being of Illinois residents by providing more affordable access to necessary pharmaceutical products.

6) **Will this rulemaking replace any emergency amendments currently in effect?** No

7) **Does this rulemaking contain an automatic repeal date?** No

8) **Does this rulemaking contain incorporations by reference?** No
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED RULES

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

11) 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:

   Joanne Scattoloni  
   Office of the General Counsel, Rules Section 
   Illinois Department of Healthcare and Family Services 
   201 South Grand Avenue East, Third Floor 
   Springfield, Illinois 62763-0002 

   (217)524-0081 

   The Department requests the submission of written comments within 30 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].

12) Initial Regulatory Flexibility Analysis:

   A) Types of small businesses, small municipalities and not-for-profit corporations affected: Pharmacies

   B) Reporting, bookkeeping or other procedures required for compliance: None

   C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on Which this Rulemaking Was Summarized: These proposed rules were not included on either of the two most recent regulatory agendas because: This rulemaking was not anticipated by the Department when the two most recent regulatory agendas were published.

The full text of the Proposed Rules is identical to the text of the Emergency Rules that appears in this issue of the Illinois Register on page 563:
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 Numbers:**
   - Proposed Action: Amendment
   - 153.125

4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 94-697

5) **Complete Description of the Subjects and Issues Involved:** Pursuant to Public Act 94-697, this proposed amendment provides a 2.69 percent rate increase for intermediate care facilities for persons with developmental disabilities (ICF/MR) and a 3 percent rate increase for developmental training (DT) agencies, effective January 1, 2006. This change will result in an annual cost increase for the Department of Human Services of approximately $9.5 million for ICFs/MR and $2.2 million for DT agencies.

6) **Will this rulemaking replace any emergency amendments currently in effect?** No

7) **Does this rulemaking contain an automatic repeal date?** No

8) **Does this rulemaking contain incorporations by reference?** No

9) **Are there any other proposed amendments pending on this Part?** No

10) **Statement of Statewide Policy Objectives:** This rulemaking does not affect units of local government.

11) **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:

    Joanne Scattoloni  
    Office of the General Counsel, Rules Section  
    Illinois Department of Healthcare and Family Services  
    201 South Grand Avenue East, Third Floor  
    Springfield, Illinois 62763-0002

    (217) 524-0081
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

The Department requests the submission of written comments within 30 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].

Any interested persons may review these proposed amendments on the Internet at http://www.dpaillinois.com/publicnotice/ Access to the Internet is available through any local public library. In addition, the amendments may be reviewed at the Illinois Department of Human Services' local offices (except in Cook County). In Cook County, the amendments may be reviewed at the Office of the Director, Department of Healthcare and Family Services, 100 West Randolph Street, Suite 10-300, Chicago, Illinois. The amendments may be reviewed at all offices Monday through Friday from 8:30 a.m. until 5:00 p.m. This Notice is being provided in accordance with federal requirements at 42 CFR 447.205.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: ICF/MR facilities and developmental training agencies

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on Which this Rulemaking Was Summarized: These proposed amendments were not included on either of the two most recent agendas because: This rulemaking was not anticipated by the Department when the two 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 616:
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENT

1) **Heading of the Part**: Conditions of Employment

2) **Code Citation**: 80 Ill. Adm. Code 303

3) **Section Number**: Adopted Action:
   303.112 Amendment

4) **Statutory Authority**: Implementing and authorized by the Personnel Code [20 ILCS 415]

5) **Effective Date of Amendment**: December 30, 2005

6) **Does this rulemaking contain an automatic repeal date?** No

7) **Does this amendment contain incorporations by reference?** No

8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) **Notice of Proposal published in the Illinois Register**: March 11, 2005; 29 Ill. Reg. 3403

10) **Has JCAR issued a Statement of Objection to this amendment?** No

11) **Differences between proposal and final version**: No substantive changes were made. The source note was edited and statutory references were italicized.

12) **Have all of the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR?** Yes

13) **Will this amendment replace any emergency amendment currently in effect?** No

14) **Are there any amendments pending on this Part?** Yes

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<td>Amendment</td>
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15) **Summary and purpose of amendment**: The amendment changes the Sick Leave Bank section to mirror the collective bargaining contract by changing the amount of time a participating employee shall retain in his or her sick leave bank account from 10 days to 5 days.
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENT

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

Gina Wilson
Illinois Department of Central Management Services
720 Stratton Office Building
Springfield IL  62706

217/785-1793

17) Does this amendment 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 Amendment begins on the next page:
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE B: PERSONNEL RULES, PAY PLANS, AND
POSITION CLASSIFICATIONS
CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 303
CONDITIONS OF EMPLOYMENT

SUBPART A: GRIEVANCE PROCEDURE

Section
303.10 Definition of a Grievance
303.20 Procedure
303.30 Grievance Committee
303.45 Representation

SUBPART B: LEAVE OF ABSENCE

Section
303.90 Sick Leave
303.100 Accumulation of Sick Leave
303.102 Payment in Lieu of Sick Leave
303.105 Reinstatement of Sick Leave
303.110 Advancement of Sick Leave
303.112 Sick Leave Bank
303.115 Veterans Hospital Leave
303.125 Leave for Personal Business
303.130 Maternity/Paternity and Adoption Leave
303.135 On-The-Job Injury – Industrial Disease
303.140 Leaves of Absence Without Pay
303.142 Leave to Attend Union Conventions
303.145 Disability Leave
303.148 Family Responsibility Leave
303.149 Organ Donor Leave
303.150 Employee Rights After Leave
303.153 Failure to Return
303.155 Leave to Take Exempt Position
303.160 Military and Peace Corps Leave
303.170 Military Reserve Training and Emergency Call-Up
303.171 Leave for Military Physical Examinations
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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303.175 Disaster Service Leave With Pay
303.176 Disaster Service Leave With Pay – Terrorist Attack
303.180 Attendance in Court
303.190 Authorized Holidays
303.200 Holiday Observance
303.215 Payment for Holidays
303.220 Holiday During Vacation
303.225 Eligibility for Holiday Pay
303.250 Vacation Eligibility
303.260 Prorated Vacation for Part-Time Employees
303.270 Vacation Schedule and Loss of Earned Vacation
303.290 Payment in Lieu of Vacation
303.295 Vacation Benefits on Death of Employee

SUBPART C: WORK HOURS AND SCHEDULES

Section
303.300 Work Schedules
303.310 Emergency Shut-Down
303.320 Overtime
303.330 Overtime Payable Upon Death
303.340 Attendance Records
303.350 Notification of Absence
303.355 Review of Attendance Records

SUBPART D: UNDATED OR INCOMPLETE FORMS

Section
303.360 Undated Forms
303.370 Incomplete Forms

SUBPART E: EMPLOYEE SEPARATIONS

Section
303.380 Reason for Separation
303.385 Repayment of Benefit Time

SUBPART F: TUITION REIMBURSEMENT

Section
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENT

303.390 Tuition Reimbursement

AUTHORITY: Implementing and authorized by the Personnel Code [20 ILCS 415] and the Organ Donor Leave Act [5 ILCS 327].


SUBPART B: LEAVE OF ABSENCE

Section 303.112 Sick Leave Bank

a) This Section contains rules governing the operation of plans allowing participating employees in each Agency to bank portions of their accrued sick leave in a sick leave bank to be used by participating employees in the same agency who have exhausted their accrued vacation time, personal days, sick leave or compensatory time. These rules provide a framework within which each Agency may administer a sick leave bank. Individual Agency procedures should be consistent with the framework set forth in these rules unless alternative
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENT

procedures have been agreed upon pursuant to collective bargaining negotiations.

b) Definitions

1) "Agency" means any branch, department, board, committee or commission of State government, but does not include units of local government, school districts or boards of election commissioners. (Ill. Rev. Stat. 1991, ch. 127, par. 4255.10) [5 ILCS 400/5.10].

2) "Sick leave bank" means a depository into which participating employees may donate accrued sick leave time for allocation to other participating employees. (Ill. Rev. Stat. 1991, ch. 127, par. 4255.15) [5 ILCS 400/5.15].

3) "Participating employee" means a permanent full- or part-time employee who has been employed by a State agency for a period of 6 months or more who voluntarily enrolls in the sick leave bank by depositing at least one full day of accrued sick leave in that bank. (Ill. Rev. Stat. 1991, ch. 127, par. 4255.20) [5 ILCS 400/5.20]. An employee who wishes to enroll must have a minimum of 510 days of accrued sick time on the books.

4) "Catastrophic illness or injury" means temporary disability or incapacity resulting from a life threatening illness or injury or illness or injury of other catastrophic proportion as determined by the Director. Factors considered by the Director shall include the length of time the employee must be absent from work due to illness or injury.

5) "Personal catastrophic illness or injury" means a catastrophic illness or injury to the employee or, if agreed upon by the Agency Head and the Director, members of the employee's immediate family. Factors to be considered in determining if an employee's immediate family members are covered include the nature and duration of the catastrophic illness or injury and whether such individuals are covered pursuant to collective bargaining negotiations.

c) Participation in the sick leave bank is voluntary on the part of any employee. Employees wishing to participate must be permanent full-time or part-time employees with a minimum of 6 months of service.

d) A participating employee may deposit into the sick leave bank as much accrued sick leave as desired provided that the participating employee shall retain in his
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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or her own account at least 5 sick days [Ill. Rev. Stat. 1991, ch. 127, par. 4260(b)] [5 ILCS 400/10(b)].

e) Employees may voluntarily enroll at any time. Employees who enroll within 30 calendar days after the establishment of a sick leave bank by an Agency must wait 30 calendar days before utilizing the sick leave bank. Employees who enroll more than 30 days after the establishment of a sick leave bank by an Agency must wait 60 calendar days after enrollment before utilizing the sick leave bank.

f) An employee may use up to 25 work days from the sick leave bank per calendar year except that participating employees shall not use sick leave accumulated in the sick leave bank until all of their accrued vacation, personal days, sick leave and compensatory time have been used. The Director may approve limits of other than 25 work days per year. Factors considered in determining if an alternate limit should be approved include:

1) the personnel jurisdiction governing the Agency and employees in question;

2) whether limits have been established through collective bargaining negotiations;

3) the desire for uniformity among Agency plans;

4) operational needs of the Agency.

g) Any sick leave in the sick leave bank used by a participating employee shall be only for the personal catastrophic illness or injury of the employee and may not be transferred, returned or used for any other purpose.

h) Each State agency shall develop procedures, consistent with this Section, for establishing a single sick leave bank for all agency employees.


j) Participating employees who transfer from one agency to another may transfer their participation in the sick leave bank. (Ill. Rev. Stat. 1991, ch. 127, par.
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENT

4260(f) [5 ILCS 400/10(f)].

k) An employee shall not be eligible to withdraw the sick leave time he or she has contributed to the bank.

l) Decisions affecting a participating employee's use of the sick leave bank may be submitted by the employee to a review committee. Unless otherwise approved by the Department, the committee shall consist of one Agency representative and two Department representatives. In determining if alternative committee membership should be approved, the Department shall consider the jurisdiction governing the Agency or employees in question. Decisions of review committees shall be final and binding.

m) Any abuse of the use of the sick leave bank shall be investigated by the agency and the Department and upon a finding of wrongdoing on the part of a participating employee, that employee shall repay all sick leave days drawn from the sick leave bank and shall be subject to other disciplinary action. (Ill. Rev. Stat. 1991, ch. 127, par. 4260(h)) [5 ILCS 400/10(h)].

(Source: Amended at 30 Ill. Reg. 329, effective December 30, 2005)
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

1) **Heading of the Part:** Internal Security Standard and Fidelity Bonds

2) **Code Citation:** 50 Ill. Adm. Code 904

3) **Section Number:**
   - 904.5 Amendment
   - 904.10 Amendment
   - 904.20 Amendment
   - 904.30 Amendment
   - 904.40 Amendment
   - 904.50 Amendment

4) **Statutory Authority:** Implementing and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401

5) **Effective Date of Amendments:** December 29, 2005

6) **Does this rulemaking contain an automatic repeal date?** No

7) **Does this rulemaking contain incorporations by reference?** No

8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the principal office of the Division of Insurance and is available for public inspection.

9) **Notice of Proposal published in Illinois Register:** May 20, 2005; 29 Ill. Reg. 7140

10) **Has JCAR issued a Statement of Objection to these amendments?** No

11) **Differences between proposal and final version:**

    In Section 904.5(b), added "domestic" before "limited health service organizations", and struck quotes around "such companies".

    Following Section 904.10(f), changed "NOTE" to "AGENCY NOTE:".

    Added the following changes to Section 904.20:

    **Section 904.20  Custody, Care and Disposition of Securities**
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

a) Transfer, sale, assignment or disposition of any security belonging to any such company, other than upon the surrender of the security thereof for payment at maturity or under an option of the maker of the security thereof to repay the security same shall be authorized or ratified by the Board of Directors, or by a committee of the Board thereof charged with the duty of supervising investments and loans.

b) Any instrument for the assignment, sale, transfer or disposition of any such securities, and all checks or other orders for disbursement of funds of the company in connection with the purchase of any such securities, shall require the signature of at least two officers or employees who shall have been so authorized by the Board of Directors, or by a committee of the Board thereof charged with the duty of supervising investments and loans.

c) Access to any and all vaults or other repositories on the premises of any company containing securities of the company and access to any safe deposit boxes containing such securities shall be limited to officers and employees designated by the Board of Directors and such designation shall require that at least two of the persons so designated shall be present at the time of entry and during the access to the vault, repository or safe deposit box.

Added the following change to Section 904.40:

Section 904.40 Bank Balance Verification

Verification of bank account balances and reconciliation of bank account statements shall be made by an officer or employee not empowered or authorized to approve payment of drafts or to make withdrawals from or charges against the accounts.

In Section 904.50(d)(1), added "Section" before "904.20".

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 amended rule replace any emergency rulemaking currently in effect? No

14) Are there any amendments pending on this Part? No
15) **Summary and purpose of rulemaking:** Section 904.5 of this Part is being amended to delete certain types of entities and add others to reflect the repeal of the Non-Profit Health Care Service Plan Act and the Medical Service Plan Act and the creation of the Limited Health Organization Act pursuant to Public Act 86-600. The proposed amendments also extend the applicability of this Part to include several additional types of entities currently covered by 50 Ill. Adm. Code 5460, which is being repealed. Housekeeping changes are being made to other Sections of this Part as well.

16) **Information and questions regarding these adopted amendments shall be directed to:**

Jeffrey Martin  
Department of Financial and Professional Regulation  
Division of Insurance  
320 West Washington Street  
Springfield, Illinois 62767-0001  
217/782-1798

The full text of the Adopted Amendments begins on the next page:
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
INSURANCE
SUBCHAPTER I: PROVISIONS APPLICABLE TO ALL COMPANIES

PART 904
INTERNAL SECURITY STANDARD AND FIDELITY BONDS

Section
904.5 Authority and Purpose
904.10 Registration of Securities
904.20 Custody, Care and Disposition of Securities
904.30 Signature of Checks – Facsimile Signatures
904.40 Bank Balance Verification
904.50 Bond Requirements


Section 904.5 Authority and Purpose

a) The following Part Rule is promulgated and adopted pursuant to and in accordance with the provisions of Section 401 of the Illinois Insurance Code.

b) All domestic insurance companies, as well as domestic health maintenance organizations, domestic limited health service organizations, dental service plan corporations, nonprofit hospital service corporations, medical service plan corporations and health services plan corporations, hereinafter referred to in this Part as such companies, are hereby directed and required, either prior to effective date of this Rule as hereinafter fixed or as soon thereafter as possible, by resolution of the Board of Directors thereof or other appropriate action, to conform their internal functions to this Part the following minimum standards:

(Source: Amended at 30 Ill. Reg. 337, effective December 29, 2005)
NOTICE OF ADOPTED AMENDMENTS

Section 904.10 Registration of Securities

All bonds, stocks, notes, shares, debentures, evidences of indebtedness, certificates of interest or participation, certificates of deposit for a security and other securities, whether negotiable or not, hereinafter referred to in this Part as "such securities", belonging to or in the possession, custody or control of any such company shall be registered, issued to, and carried in the name of such company except:

a) Securities pledged or hypothecated with such company as security for indebtedness or obligations to such company;

b) Securities deposited by or with such company as collateral on fidelity or surety bonds written for or by such company;

c) Securities that are only issuable in bearer form, i.e., securities that cannot be issued in registered form;

d) Securities in "custodial" accounts maintained with a bank or trust company licensed by the United States or any state and thereof which said bank or trust company is regularly examined by the licensing authority, provided that such "custodial" accounts shall be the undivided responsibility of the depository and provided further that such "custodial" account shall be established conformably with and conducted in compliance with Section 904.20 of this Rule;

e) Securities in street form and in the custody of a registered dealer in securities, for a period not exceeding 30 days as to any security, provided that no such registered dealer in securities shall be an officer, director, agent or employee of the owner of such securities and provided further that accounts with the dealers shall be established conformably with and conducted in compliance with Section 904.20 of this Rule;

f) Securities deposited with any state insurance department or similar authority pursuant to any requirement for such deposit if such deposit may be made in "bearer" securities.*

*AGENCY NOTE: Illinois will not accept "bearer" securities as a part of a company's deposit.

(Source: Amended at 30 Ill. Reg. 337, effective December 29, 2005)
NOTICE OF ADOPTED AMENDMENTS

Section 904.20  Custody, Care and Disposition of Securities

a) Transfer, sale, assignment or disposition of any security belonging to any such company, other than upon the surrender of the security thereof for payment at maturity or under an option of the maker of the security thereof to repay the security same shall be authorized or ratified by the Board of Directors, or by a committee of the Board thereof charged with the duty of supervising investments and loans.

b) Any instrument for the assignment, sale, transfer or disposition of any such securities, and all checks or other orders for disbursement of funds of the company in connection with the purchase of any such securities, shall require the signature of at least two officers or employees who shall have been so authorized by the Board of Directors, or by a committee of the Board thereof charged with the duty of supervising investments and loans.

c) Access to any and all vaults or other repositories on the premises of any company containing securities of the company and access to any safe deposit boxes containing such securities shall be limited to officers and employees designated by the Board of Directors and such designation shall require that at least two of the persons so designated shall be present at the time of entry and during the access to the such vault, repository or safe deposit box.

(Source: Amended at 30 Ill. Reg. 337, effective December 29, 2005)

Section 904.30  Signature of Checks – Facsimile Signatures

a) All checks, except as hereinafter provided in this subsection (a), issued for the disbursement of funds belonging to such company shall require the signature of at least two officers or employees of the company who shall have been so authorized by the Board of Directors of such company. This dual signature requirement shall not apply to drafts.

1) Checks in amounts less than $5,000 may, if, and to the extent, authorized by the Board, be issued without such dual signatures if the procedure to be followed pursuant to the such authorization requires an officer or employee, other than the authorized signer, to approve such payment prior to the issuance of the such check.

2) Checks for payment of claims only, in amounts of $5,000 or more and
NOTICE OF ADOPTED AMENDMENTS

less than $20,000, may, if, and to the extent, authorized by the Board, be issued without such dual signatures provided the requirements of subsection (a)(1) above are met, and further provided that:

A) The company has prepared a list of authorized signers by name or job classification, with approved limits of authority for each authorized signer. This list must be approved by the Board and a copy must be kept on file and available for review by the Department of Financial and Professional Regulation-Division of Insurance examiners.

B) Verification of compliance with this subsection (a) these procedures must be documented by the company's outside independent certified public accountants or the internal audit staff of the company, provided the such staff report directly to an audit committee appointed by the Board of Directors. This compliance review must be performed annually.

b) Facsimile signatures may be affixed to checks or drafts if such procedure has been authorized by the Board of Directors and adequate controls over the use of facsimile signatures have been established. Control procedures shall be reduced to writing and shall provide for written approval of the disbursement of funds by officers or employees other than those affixing facsimile signatures, for supervision and policing of the machines or appliances used for affixing facsimile signatures, and for the recording of checks and drafts to which facsimile signatures have been affixed. Written control procedures shall be kept on file and available for review by examiners.

(Source: Amended at 30 Ill. Reg. 337, effective December 29, 2005)

Section 904.40 Bank Balance Verification

Verification of bank account balances and reconciliation of bank account statements shall be made by an officer or employee not empowered or authorized to approve payment of drafts or to make withdrawals from or charges against such accounts.

(Source: Amended at 30 Ill. Reg. 337, effective December 29, 2005)

Section 904.50 Bond Requirements
NOTICE OF ADOPTED AMENDMENTS

a) All such companies shall procure and maintain in force surety bonds on employees, officers or positions in an amount not less than the amount set forth in the column in subsection (d) headed "Minimum Amount of Bond", based on the amount of admitted assets of the company (as determined from year to year hereafter) stated in the annual statement of such company as filed with the Illinois Insurance Department Division of Insurance. All such bonds shall be written with at least a one year discovery period and, if written with less than a 3 year discovery period, shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of such cancellation or termination has been filed with the Division Illinois Department of Insurance unless an earlier date of such cancellation or termination is approved by the said Division Department of Insurance.

b) Such bonds required by this Section shall include all employees, officers or positions for the following perils, which may be covered under separate policies:

1) Dishonesty of employees and officers;

2) Robbery, burglary, larceny, theft, false pretense, holdup, misplacement, mysterious disappearance, and damage or destruction while property is in any bank or any recognized place of safe deposit, or in transit;

3) Forgery or alteration.

c) Such surety bond may be written under a deductible form, the amount of the deductible to be not more than the greatest of either:

1) \( \frac{1}{2} \) of 1% of the capital and surplus, if a stock company, and, if a company other than stock, its surplus over all liabilities (as determined from year to year hereafter) stated in the annual statement of such company filed with the Division of Illinois Insurance Department; or

2) 10% of the total bond requirement as provided in subsection paragraph (a) of this Section.

Provided, however, the deductible amount shall not in any case exceed $500,000.00.

d) If the total bond requirement of a company under subsection as provided in sub-
NOTICE OF ADOPTED AMENDMENTS

paragraph (a) of this Section is in excess of $100,000, the such excess may be written on an excess of loss basis to cover only the peril of dishonesty and may be limited to cover the following officers or employees:

1) All officers and employees authorized by the Board of Directors to act under the terms and provisions of Section 904.20 of this Part;

<table>
<thead>
<tr>
<th>TOTAL ADMITTED ASSETS</th>
<th>MINIMUM AMOUNT OF BOND</th>
</tr>
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<tbody>
<tr>
<td>Under $100,000</td>
<td>$2,000 plus 8% of total assets</td>
</tr>
<tr>
<td>More than $100,000</td>
<td></td>
</tr>
<tr>
<td>$100,000</td>
<td>$1,000 plus 4% of assets over $100</td>
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<tr>
<td>600,000</td>
<td>30,000 plus 3½% of assets over 600</td>
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<td>100,000 plus 2% of assets over 3,200</td>
</tr>
<tr>
<td>4,450,000</td>
<td>125,000 plus 1⅔% of assets over 4,450</td>
</tr>
<tr>
<td>6,450,000</td>
<td>150,000 plus ⅞% of assets over 6,450</td>
</tr>
<tr>
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<td>675,000 plus ⅘% of assets over 90,450</td>
</tr>
<tr>
<td>350,450,000</td>
<td>1,625,000 plus ⅘% of assets over 350,450</td>
</tr>
<tr>
<td>1,070,450,000</td>
<td>3,075,000 plus ⅞% of assets over 1,070,450</td>
</tr>
</tbody>
</table>

until total bond equals $5,000,000.

2) Officers and employees authorized by the Board of Directors to act under the terms of Section 904.30 of this Rule, except that one or more of the employees of this category may be excluded by action of the Board of Directors;

3) Such other officers or employees as may be included in the resolution of the Board of Directors authorizing the procurement of coverage on such excess of loss basis.

e) Surety bonds covering affiliated and/or subsidiary companies which are substantially under the same management and control may be written to cover such affiliated and/or subsidiary companies jointly. The total admitted assets of the affiliated and/or subsidiary company having the largest total admitted assets shall be used in calculating the amount of surety cover required under subsection paragraph (a) of this Section.
f) Surety bonds for any company shall not be procured by such company from affiliated and/or subsidiary companies which are substantially under the same management and control as the company being bonded.

g) Notwithstanding any other provision of this Section 904.50 of this Rule, any such company may elect to self insure the required surety bond if:

1) the company has, and maintains at all times while self insured, net admitted assets, in excess of all reserves and other liabilities, of more than $25,000,000;

2) such self insurance does not cover any officer or director of the company;

3) the total number of employees covered under such self insurance is not more than 1% of the employees of such company, exclusive of all officers and directors; and

4) such self insurance is evidenced by a "Certificate of Self Insurance" in an appropriate form, specifically setting forth the liabilities and responsibilities of the company in regard thereto in accordance with this Section and including an addendum setting forth, by name or position, each employee covered, at any time, under such self insurance.

(Source: Amended at 30 Ill. Reg. 337, effective December 29, 2005)
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED REPEALER

1) **Heading of the Part**: Internal Security Standard and Fidelity Bonds

2) **Code Citation**: 50 Ill. Adm. Code 5460

3) **Section Number**: Table of Adopted Action

<table>
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<tbody>
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<td>5460.5</td>
<td>Repeal</td>
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<tr>
<td>5460.10</td>
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<tr>
<td>5460.20</td>
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<td>5460.50</td>
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4) **Statutory Authority**: Implementing and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401].

5) **Effective Date of Repealer**: December 29, 2005

6) **Does this rulemaking contain an automatic repeal date?** No

7) **Does this rulemaking contain incorporations by reference?** No

8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the principal office of the Division of Insurance and is available for public inspection.

9) **Notice of Proposal published in Illinois Register**: May 20, 2005; 29 Ill. Reg. 7148

10) **Has JCAR issued a Statement of Objection to these amendments?** No

11) **Differences between proposal and final version**: None

12) **Have all changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR?** Yes

13) **Will this rulemaking replace an emergency rulemaking currently in effect?** No

14) **Are there any amendments pending on this Part?** No

15) **Summary and purpose of rulemaking**: This Part is being repealed because it is nearly identical to 50 Ill. Adm. Code 904, which creates confusion regarding the applicability of
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED REPEALER

each of the two Parts. The duplication was the result of a previous recodification. Part 904 is simultaneously being amended to extend its applicability to several types of entities currently covered under Part 5460 through its inclusion under Subchapter kkk of the Division’s administrative regulations. Certain types of entities currently covered under Parts 904 and 5460 are being deleted and others added to Part 904 to reflect the repeal of the Non-Profit Health Care Service Plan Act and the Medical Service Plan Act and the creation of the Limited Health Organization Act pursuant to Public Act 86-600.

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

Jeffrey Martin
Department of Financial and Professional Regulation
Division of Insurance
320 West Washington Street
Springfield, Illinois 62767-0001

217/782-1798
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENT

1) **Heading of the Part:** Medical Payment

2) **Code Citation:** 89 Ill. Adm. Code 140

3) **Section Number:** 140.80  
   **Adopted Action:** Amendment

4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 94-0242

5) **Effective Date of Amendment:** December 28, 2005

6) **Does this rulemaking contain an automatic repeal date?** No

7) **Does this amendment contain incorporations by reference?** No

8) A copy of the adopted amendment, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) **Notice of Proposal published in Illinois Register:** August 12, 2005; 29 Ill. Reg. 12338

10) **Has JCAR issued a Statement of Objection to these rules?** No

11) **Differences between Proposal and Final Version:** No changes have been made to the proposed rulemaking.

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 amendment replace an emergency amendment currently in effect?** Yes (29 Ill. Reg. 12534)

14) **Are there any other amendments pending on this Part?** Yes

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<tr>
<td>140.463</td>
<td>Amendment</td>
<td>September 30, 2005; 29 Ill. Reg. 14463</td>
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15) Summary and purpose of amendment: These changes pertain to the Department’s hospital provider assessment provisions at Section 140.80. Changes are being made concerning the Hospital Provider Fund pursuant to Public Act 94-0242 to establish a new annual assessment on hospital providers for State fiscal years 2006, 2007 and 2008, in an amount equal to 2.5835 percent of the hospitals adjusted gross hospital revenue for inpatient services and 2.5835 percent of the hospital’s adjusted gross hospital revenue for outpatient services. These changes are expected to increase the Hospital Provider Fund by $733.8 million during fiscal years 2006, 2007 and 2008. The Fund will allow for certain new hospital access improvement payments to ensure the availability of essential medical care.

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

Joanne Scattoloni
Office of the General Counsel, Rules Section
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, Third Floor
Springfield, Illinois  62763-0002

217/524-0081

The full text of the Adopted Amendment begins on the next page:
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**

**NOTICE OF ADOPTED AMENDMENT**

**TITLE 89: SOCIAL SERVICES**

**CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**

**SUBCHAPTER d: MEDICAL PROGRAMS**

**PART 140**

**MEDICAL PAYMENT**

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## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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<td>Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments</td>
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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 305 ILCS 5/5A-4 and 12.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) of this Section;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) Monies transferred from another fund in the State treasury;

E) All other monies received for the Fund from any other source, including interest earned on those monies.

b) Provider Assessments

1) An annual assessment on hospital inpatient services is imposed on each hospital provider in an amount equal to the hospital's occupied bed days multiplied by $84.19 for State fiscal years 2004 and 2005, if the payment
methodologies required under 305 ILCS 5/5A-12 and the waiver created under 42 CFR 433.68 are approved with an effective date prior to July 1, 2004; or the assessment will be imposed for fiscal year 2005 only, if the payment methodologies required under 305 ILCS 5/5A-12 and the waiver created under 42 CFR 433.68 are approved with an effective date on or after July 1, 2004. The Department shall use the number of occupied bed days as reported, by February 3, 2004 (the date of enactment of Public Act 93-0659), by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health to calculate the hospital's annual assessment. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals or if there are data errors in the reported sum of a hospital's occupied bed days as determined by the Department, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

2) Subject to the provisions of 305 ILCS 5/5A-3 and 5A-10, for the privilege of engaging in the occupation of hospital provider, beginning August 1, 2005, an annual assessment is imposed on each hospital provider for State fiscal years 2006, 2007 and 2008, in an amount equal to 2.5835 percent of the hospital provider's adjusted gross hospital revenue for inpatient services and 2.5835 percent of the hospital provider's adjusted gross hospital revenue for outpatient services. If the hospital provider's adjusted gross hospital revenue is not available, then the Department may obtain the hospital provider's adjusted gross hospital revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

c) Payment of Assessment Due

1) The annual assessment imposed for State fiscal year 2004 shall be due and payable on June 18, 2004. The assessment imposed for State fiscal year 2005 shall be due and payable in quarterly installments, each equaling one-fourth of the assessment for the year on the 14th business day of September, December, March and May, on July 19, October 19, January 18, and April 19 of the year. No installment payments of an assessment shall be due and payable, however, until after:
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A) The hospital provider receives written notice from the Department that the payment methodologies to hospitals required under 305 ILCS 5/5A-12 or 5A-12.1, whichever is applicable for that fiscal year, have been approved by CMS the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services and any waiver necessary under 42 CFR 433.68 for the assessment has been granted by CMS the Centers for Medicare and Medicaid Services; and

B) The hospital has received payments required under 305 ILCS 5/5A-12 or 5A-12.1, whichever is applicable for that fiscal year Public Act 93-0659.

2) Assessment payments postmarked on the due date will be considered as paid on time. Upon notification to the Department of approval of the payment methodologies to hospitals required under 305 ILCS 5/5A-12 or 5A-12.1 by the Centers for Medicare and Medicaid Services (CMS) of the federal Department of Health and Human Services, and any waiver necessary under 42 CFR 433.68 for the assessment has been granted by the CMS, all quarterly installments otherwise due under 305 ILCS 5/5A-12 prior to the date of notification shall be due and payable to the Department upon written direction from the Department and the receipt of the payments required under Section 5A-12 or Section 5A-12.1 within 30 days after the date of notification.

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.

d) Notice Requirements, Penalty, and Maintenance of Records

1) The Department shall send a notice of assessment to every hospital provider subject to an assessment under subsection (b) of this Section, except that the notice for the State fiscal year commencing July 1, 2003, shall be sent on or before June 1, 2004, and no notice shall be sent until the Department receives written notice that the payment methodologies to hospitals required under 305 ILCS 5/5A-12 or 5A-12.1 have been approved by the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services and the waiver under
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42 CFR 433.68 for the assessment has been granted by CMS the Centers for Medicare and Medicaid Services.

2) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, a separate notice shall be sent for each hospital.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. If a hospital provider ceases to conduct, operate, or maintain a hospital for which the person is subject to assessment under subsection (b) of this Section, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) of this Section by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate or maintain a hospital, the person shall pay the assessment for the year as adjusted (to the extent not previously paid).

2) Commencing of business during the fiscal year in which the assessment is being paid. A hospital provider who commences conducting, operating, or maintaining a hospital for which the person is subject to assessment under subsection (b) of this Section, upon notice by the Department, shall pay the assessment under subsection (d) of this Section as computed by the Department in installments on the due dates stated on the notices and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment notice. In determining the annual assessment amount for the provider, the Department shall develop hypothetical adjusted gross hospital revenue for the hospital's first full fiscal year, which may be based on the annualization of the provider's actual revenues for a portion of the year, or revenues of a comparable hospital for the year, including revenues realized by a prior hospital provider of the same hospital during the year annualized occupied bed projections based upon geographic location, facility size and patient case mix or, if there is not enough information to develop a methodology, may base the projection on the average occupied bed percentage of all hospitals in the State. The assessment determination made by the Department is final.
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3) Partial Calendar Year Operation Adjustment. For a hospital provider that did not conduct, operate, or maintain a hospital throughout the entire calendar year reporting period, the assessment for the State fiscal year shall be annualized based on the provider's actual adjusted gross hospital revenue occupied bed information for the portion of the reporting period the hospital was operational (dividing adjusted gross hospital revenue occupied beds by the number of days the hospital was in operation and then multiplying the amount by 365). Adjusted gross hospital revenue occupied bed 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 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 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) of this Section.

f) Penalties

1) Any hospital that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to 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. Waiver due to reasonable cause may include but is not limited to:

A) A provider can demonstrate to the Department's satisfaction that a payment was made prior to the due date.
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B) A 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) of this Section will continue to accrue during the recoupment process. Recoupment proceedings against the same hospital two times in a fiscal year may be cause for termination from the Medicaid Program. Failure by the Department to initiate recoupment activities within 30 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the hospital does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment – Groups of Hospitals
The Department may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

1) The State delays payments to hospitals due to problems related to State cash flow; or

2) A cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a
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significant number of hospitals will be unable to obtain a loan to pay the assessment.

h) Delayed Payment – Individual Hospitals
In addition to the provisions of subsection (g) of this Section, the Department may delay assessments for individual hospitals that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) of this Section.

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 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) and (f)(2) 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) 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;

ii) Cash flow problems encountered by a provider which 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 provider serves a significant number of clients under the medical assistance program. "Significant" in this instance means:

i) A hospital that serves a significant number of clients under the medical assistance program; significant in this instance means that the hospital qualifies as a
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disproportionate share hospital (DSH) under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(5); or qualifies as a Medicare DSH hospital under the current federal guidelines.

ii) A government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) of this Section.

iii) A hospital which has filed for Chapter 11 bankruptcy, which meets the cash flow criteria under subsection (h)(1)(A)(ii) of this Section.

C) The provider must file a delay of payment request as defined under subsection (h)(3)(A) of this Section, and the request must include a Cash Position Statement which 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 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 which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.

D) The provider must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) The provider must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:
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i) Specific reasons for institution of the delayed payment provisions;

ii) Specific dates on which payments must be received and the amount of payment 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 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) Such other terms and conditions that may be required by the Department.

2) A hospital which does not meet the above criteria; may request a delayed payment schedule. The Department may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, providers must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the date designated by the Department. Providers will be notified, in writing, as to the
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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 assessment as defined in subsection (h)(1)(D) of this Section and an explanation of the risk of irreparable harm to the clients; and

iii) Specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) of this Section, such 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 such penalties shall be fully reinstated.
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5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) of this Section. The interest may be waived by the Department if the facility's current ratio, as described in subsection (h)(1)(C) of this Section, is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B) of this Section. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) of this Section.

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delayed payment agreement. The waiver of penalties described in subsection (h)(4) of this Section shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions
The Department shall establish and maintain a listing of all hospital providers appearing in the licensing records of the Department of Public Health, which shall show each provider's name and principal place of business and the name and address of each hospital operated, conducted, or maintained by the provider in this State. The Department shall administer and enforce 305 ILCS 5/5A-1, 2, 3, 4, 5, 7, 8, 10 and 12 and collect the assessments and penalty assessments imposed under 305 ILCS 5/5A-2 and 4. 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 305 ILCS 5/5A-1, 2, 3, 4, 5, 7, 8, 10 and 12. Administrative enforcement proceedings initiated shall be governed by the Department's rules at 89 Ill. Adm. Code 104.200 through 104.330. Judicial enforcement proceedings initiated shall be governed by the rules of procedure applicable in the courts of this State.

2) No proceedings for collection, refund, credit, or other adjustment of an assessment amount shall be issued more than three years after the due date
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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 305 ILCS 5/5A-2 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 305 ILCS 5/5A-1, 2, 3, 4, 5, 7, 8, 10 and 12, the seller or transferee shall pay the Department the amount of any assessment, assessment penalty, and interest (if any) due from it under 305 ILCS 5/5A-2 and 4 up to the date of the sale or transfer. If the seller or transferee fails to pay any assessment, assessment penalty, and interest (if any) due, the purchaser or transferee of such asset shall be liable for the amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Department a certificate showing that such assessment, penalty, and interest have been paid or a certificate from the Department showing that no assessment, penalty, or interest is due from the seller or transferee under 305 ILCS 5/5A-2, 4 and 5.

4) Payments under 305 ILCS 5/5A-4 are not subject to the Illinois Prompt Payment Act. Credits or refunds shall not bear interest.

5) In addition to any other remedy provided for and without sending a notice of assessment liability, the Department may collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Department to the hospital provider.

j) Exemptions
The following classes of providers are exempt from the assessment imposed under 305 ILCS 5/5A-4 unless the exemption is adjudged to be unconstitutional or otherwise invalid:
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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.

3) **For State fiscal years 2004 and 2005, a** hospital provider whose hospital does not charge for its services.

4) **For State fiscal years 2004 and 2005, a** hospital provider whose hospital is licensed by the Department of Public Health as a psychiatric hospital.

5) **For State fiscal years 2004 and 2005, a** hospital provider whose hospital is licensed by the Department of Public Health as a rehabilitation hospital.

6) **For State fiscal years 2004 and 2005, a** hospital provider whose hospital is not a psychiatric hospital, rehabilitation hospital, or children's hospital and has an average length of inpatient stay greater than 25 days.

k) Nothing in 305 ILCS 5/5A-4 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before February 3, 2004.

l) Definitions.

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

1) "Adjusted gross hospital revenue for inpatient services" means inpatient gross revenue less Medicare gross inpatient revenue, which shall be determined using the most recent data available from each hospital's 2003 Medicare cost report as contained in the HCRIS file for the quarter ending December 31, 2004, without regard to any subsequent adjustments or changes to that data.

2) "Adjusted gross hospital revenue for outpatient services" means outpatient gross revenue less Medicare gross outpatient revenue, which shall be determined using the most recent data available from each hospital's 2003 Medicare cost report as contained in the HCRIS file for the quarter ending December 31, 2004, without regard to any subsequent adjustments or changes to such data.
3) "CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

4) "Department" means the Illinois Department of Healthcare and Family Services Public Aid.

5) "Fund" means the Hospital Provider Fund.

6) "HCRIS" means the federal Centers for Medicare and Medicaid Services Healthcare Cost Report Information System.

7) "Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

8) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

9) "Inpatient Gross Revenue" means total inpatient gross revenue, as reported on the HCRIS Worksheet C, Part 1, Column 6, Line 101, less the sum of the following lines (including any subset lines of these lines):

   A) Line 34: Skilled Nursing Facility.
   B) Line 35: Other Nursing Facility.
   C) Line 35.01: Intermediate Care Facility for the Mentally Retarded.
   D) Line 36: Other Long Term Care.
   E) Line 45: PBC Clinical Laboratory Services – Program Only.
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F) Line 60: Clinic.

G) Line 63: Other Outpatient Services.

H) Line 64: Home Program Dialysis.


K) Line 67: Durable Medical Equipment – Sold.

L) Line 68: Other Reimbursable.

10) "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):
   
   
   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.
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11) "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).

12) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds, excluding beds classified as long term care beds and assessed a licensed bed fee during calendar year 2001. Occupied bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

13) "Outpatient Gross Revenue" means the amount from the HCRIS Worksheet C, Part I, Column 7. Line 101 less the sum of lines 45, 60, 63, 64, 65, 66, 67 and 68 (and any subset lines of these lines).

(Source: Amended at 30 Ill. Reg. 349, effective December 28, 2005)
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1) **Heading of the Part:** Hospital Services

2) **Code Citation:** 89 Ill. Adm. Code 148

3) **Section Numbers:**
   - 148.310  Amendment
   - 148.402  New Section
   - 148.404  New Section
   - 148.406  New Section
   - 148.408  New Section
   - 148.410  New Section
   - 148.412  New Section
   - 148.414  New Section
   - 148.416  New Section
   - 148.418  New Section
   - 148.420  New Section
   - 148.422  New Section
   - 148.424  New Section
   - 148.426  New Section
   - 148.428  New Section
   - 148.430  New Section
   - 148.432  New Section
   - 148.434  New Section

4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 94-0242

5) **Effective Date of Amendments:** December 28, 2005

6) **Does this rulemaking contain an automatic repeal date?** No

7) **Do these amendments contain incorporations by reference?** No

8) A copy of the adopted amendments, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) **Notice of Proposal published in Illinois Register:** July 1, 2005; 29 Ill. Reg. 9241

10) **Has JCAR issued a Statement of Objection to these amendments?** No
11) Differences between Proposal and Final Version:

Section 148.402

In subsection (b)(2), "148.25(b)(6)" has been changed to "148.25(b)(1)(B)".

In subsection(c)(1), "growth percentage" has been changed to "the change in the growth percentage".

Section 148.404

In subsection (b)(2), "148.25(b)(6)" has been changed to "148.25(b)(1)(B)".

Section 148.406

In subsection (b)(2), "148.25(b)(6)" has been changed to "148.25(b)(1)(B)".

In subsection (c)(2), "equal to or" has been added after "ratio percentage".

Section 148.408

In subsection (b)(2), "148.25(b)(6)" has been changed to "148.25(b)(1)(B)".

In subsection (c)(1)(A), "an" has been added after "large urban area or".

Section 148.410

In subsection (a), "an Illinois" has been added after "Illinois psychiatric hospital and".

Subsection (e)(1) has been revised to read, "the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;".

Section 148.412

In subsection (b)(2), "148.25(b)(6)" has been changed to "148.25(b)(1)(B)".

Section 148.414
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Subsection (e)(1) has been revised to read, "the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;".

Section 148.416

In subsection (a), "a general acute care hospital" has been changed to "an Illinois general acute care hospital".

In subsection (a), "as described in Section 148.270(c)(1)" has been moved to follow "general acute care hospital".

In subsections (b)(2) and (b)(3), "148.25(b)(6)" has been changed to "148.25(b)(1)(B)".

In subsection (c)(2), "another" has been changed to "an other".

Section 148.418

Subsection (e)(1) has been revised to read, "the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;".

Section 148.420

In subsections (b)(2) and (b)(3), "148.25(b)(6)" has been changed to "148.25(b)(1)(B)".

In subsection (c)(4), "growth rate" has been changed to "growth percentage rate".

In subsection (e)(1), the definition has been changed to read, "Emergency care percentage means a fraction, the numerator of which is the total Category 3 ambulatory procedure listing services, excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2003 contained in the Department's data base adjudicated through June 30, 2004, and the denominator of which is the total ambulatory procedure listing services, excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2003 contained in the Department's data base adjudicated through June 30, 2004."

In subsection (e)(2), a definition has been added as follows: "Growth percentage means, for a given hospital, the percentage of change in the growth of Medicaid clients within
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the county where the hospital is located from 1998 to 2003." The remaining definitions in subsection (e) have been renumbered accordingly.

In subsection (e)(3) (newly relabeled definition for “Large urban area”), ", and with an urban hospital as described in Section 148.25(g)(4)" has been deleted.

Section 148.422

In the second sentence of subsection (b)(1), "percentage" has been added after "growth".

In subsection (d)(1), a definition has been added as follows: "Growth percentage” means, for a given hospital, the percentage of change in the growth of Medicaid clients within the county where the hospital is located from 1998 to 2003." The remaining definitions in subsection (d) have been renumbered accordingly.

Subsection (e)(1) has been revised to read, "the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;".

Section 148.424

Subsection (e)(1) has been revised to read, "the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;".

Section 148.426

In subsection (a), "as described in Section 148.25(g)(4)," has been added after "urban area,"

In subsection (d)(2), the definition has been changed to read, "Emergency care percentage" means a fraction, the numerator of which is the total Category 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 2003 contained in the Department’s data base adjudicated through June 30, 2004, 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 2003 contained in the Department's data base adjudicated through June 30, 2004."
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In subsection (d)(3), "outpatient access" has been changed to "outpatient complexity of care".

Subsection (e)(1) has been revised to read, "the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;".

Section 148.428

In subsections (b)(2), "148.25(b)(6)" has been changed to "148.25(b)(1)(B)".

Section 148.430

In subsection (a), “general acute care hospitals” has been changed to "Illinois general acute care hospitals".

In subsections (b)(2), "148.25(b)(6)" has been changed to "148.25(b)(1)(B)".

Section 148.432

Subsection (e)(1) has been revised to read, "the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;".

Section 148.434

Subsection (e)(1) has been revised to read, "the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;".

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 amendments replace any emergency amendments currently in effect? Yes (29 Ill. Reg. 12568)

14) Are there any other amendments pending on this Part? Yes

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148.140 Amendment   September 30, 2005 (29 Ill. Reg. 14502)
148.295 Amendment   November 28, 2005 (29 Ill. Reg. 19043)

15) Summary and purpose of amendments: These amendments concerning hospital services are being adopted pursuant to Public Act 94-0242 under which a number of new quarterly rate adjustment programs have been established to preserve and improve access to hospital services. This rulemaking describes the eligibility requirements and rate methodology for each of these hospital access improvement payments. These new adjustment payment programs include:

Medicaid Eligibility Payments,
Medicaid High Volume Adjustment Payments,
Intensive Care Adjustment Payments,
Trauma Center Adjustment Payments,
Psychiatric Rate Adjustment Payments,
Rehabilitation Adjustment Payments,
Supplemental Tertiary Care Adjustment Payments,
Crossover Percentage Adjustment Payments,
Long Term Acute Care Hospital Adjustments Payments,
Obstetrical Care Adjustment Payments,
Outpatient Access Payments,
Outpatient Utilization Payments,
Outpatient Complexity of Care Adjustment Payments,
Rehabilitation Hospital Adjustment Payments,
Perinatal Outpatient Adjustment Payments,
Supplemental Psychiatric Adjustment Payments, and
Outpatient Community Access Adjustment Payments.

The changes to Section 148.310 add rate review provisions for each new rate adjustment program.

16) Information and questions regarding these adopted amendments shall be directed to:

Joanne Scattoloni
Office of the General Counsel, Rules Section
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, Third Floor
Springfield, Illinois 62763-0002

217/524-0081
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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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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. 10275, effective July 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 5514, effective April 1, 2005; emergency amendment at 29 Ill. Reg. 5756, effective April 8, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 11622, effective July 5, 2005, for the remainder of the 150 days; amended at 29 Ill. Reg. 8363, effective June 1, 2005; emergency amendment at 29 Ill. Reg. 10275, effective July 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12568, effective August 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 15629, effective October 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19973, effective November 23, 2005; emergency amendment at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 383, effective December 28, 2005.

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.310 Review Procedure

a) Inpatient Rate Reviews

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.
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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., 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 (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 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.
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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(k)(4). Review 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(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 (c)(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, Section 148.120(a)(2) and (d), and Section 148.122(a)(2) and (c). 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
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Ill. Adm. Code 1100) based upon the methodologies utilized by, and the most current information available to, the Illinois Health 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(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 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

1) 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 that the information supplied to and utilized by the Department was incorrect.
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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.

f) Medicaid High Volume Adjustment Reviews
The Department shall make Medicaid high volume adjustments in accordance with Section 148.290(d). 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.

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 148.295(a)(3)(B) and (b)(3) based upon the methodologies utilized by, and the most current information available to, the Department
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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 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
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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.

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
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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 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.
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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 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.
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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 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 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.
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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 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.
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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 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
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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 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
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.

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
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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. 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 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.
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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 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
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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.

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.

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.

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.
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(Source: Amended at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.402  Medicaid Eligibility Payments

a)  Qualifying Criteria. Medicaid Eligibility 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 was assessed as described in 89 Ill. Adm. Code 140.80 for the rate year 2006 determination.

b)  The following classes of hospitals are ineligible for Medicaid Eligibility Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1)  County-owned hospitals as described in Section 148.25(b)(1)(A).

2)  Hospitals organized under the University of Illinois Hospital Act, 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).

c)  Medicaid Eligibility Payments

1)  A hospital qualifying under subsection (a) of this Section shall receive payment equal to the product of $430 multiplied by the qualifying hospital's Medicaid admissions in the Medicaid eligibility base year, multiplied by the change in the growth percentage of Medicaid clients within the hospital's county from State fiscal year 1998 to State fiscal year 2003.

2)  A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d)  Payment to a Qualifying Hospital

1)  For the Medicaid eligibility adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital.
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in four equal installments on or before the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) 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

1) "Growth percentage" means, for a given hospital, the percentage of change in the growth of Medicaid clients within the county where the hospital is located from 1998 to 2003.

2) "Medicaid admissions" means, for a given hospital, the sum of admissions 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), as tabulated from the Department's paid claims data for admissions occurring in the Medicaid eligibility base period that were adjudicated by the Department through June 30, 2004.

3) "Medicaid eligibility adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

4) "Medicaid eligibility base period" means the 12-month period beginning on July 1, 2002, and ending on June 30, 2003.

f) 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;
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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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.404 Medicaid High Volume Adjustment Payments

a) Qualifying Criteria. Medicaid 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 is:

1) an Illinois hospital that did not qualify for Medicaid Percentage Adjustments as described in Section 148.122 for the 12-month period beginning on October 1, 2004 and provided more than 10,000 Medicaid inpatient days in the Medicaid high volume base period; or

2) an Illinois general acute care hospital defined in Section 148.270(c)(1) that did qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 for the 12-month period beginning on October 1, 2004 and provided more than 21,000 Medicaid inpatient days in the Medicaid high volume base period.

b) 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) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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).

e) Medicaid High Volume Adjustment Payments
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1) For a hospital qualifying under subsection (a)(1) of this Section, payment is as follows:

   A) A hospital that:

      i) provided less than or equal to 14,500, but more than 10,000, Medicaid inpatient days in the Medicaid high volume base period shall receive payments equal to the product of $90 multiplied by the qualifying hospital's Medicaid inpatient days;

      ii) provided less than or equal to 18,500, but more than 14,500, Medicaid inpatient days in the Medicaid high volume base period shall receive payments equal to the product of $135 multiplied by the qualifying hospital's Medicaid inpatient days;

      iii) provided less than or equal to 20,000, but more than 18,500, Medicaid inpatient days in the Medicaid high volume base period shall receive payments equal to the product of $225 multiplied by the qualifying hospital's Medicaid inpatient days; or

      iv) provided 20,000 or more Medicaid inpatient days in the Medicaid high volume base period shall receive payments equal to the product of $900 multiplied by the qualifying hospital's Medicaid inpatient days.

   B) Payments will be the lesser of the calculation described in subsection (c)(1)(A)(i), (c)(1)(A)(ii), (c)(1)(A)(iii), and (c)(1)(A)(iv) or $19 million dollars.

2) For a hospital qualifying under subsection (a)(2) of this Section:

   A) Payment equal to the product of $35 multiplied by the qualifying hospital's Medicaid inpatient days.

   B) Payments will be the lesser of the calculation described in subsection (c)(2)(A) or $1,200,000.
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3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection.

d) Payment to a Qualifying Hospital

1) For the Medicaid high volume adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) 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

1) "Medicaid high volume adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

2) "Medicaid high volume base period" means the cost report on file with the Department on July 1, 2004, for the hospital’s fiscal year ending in 2002.

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 the Act (Medicaid/Medicare crossover days), as contained in the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.406 Intensive Care Adjustment Payments

a) Qualifying Criteria. Intensive Care Adjustment Payments shall be made to qualifying Illinois general acute care hospitals as described in Section 148.270(c)(1). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if the hospital is located in a large urban area and has a ratio of Medicaid intensive care days to total Medicaid days greater than 19 percent for the intensive care adjustment period.

b) The following classes of hospitals are ineligible for Intensive Care Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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).

c) Intensive Care Adjustment Payments

1) Each qualifying hospital with an intensive care ratio of less than 30 percent, shall receive payment equal to the product of:

   A) The ratio of Medicaid intensive care days to total Medicaid days;

   B) Multiplied by total Medicaid days;
C) Multiplied by $1,000.

2) Each qualifying hospital with an intensive care ratio percentage equal to or greater than 30 percent shall receive payment equal to the product of:
   A) The ratio of Medicaid intensive care days to total Medicaid days;
   B) Multiplied by total Medicaid days;
   C) Multiplied by $2,800.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the intensive care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) 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

1) "Intensive care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

2) "Intensive care base period" means the cost report on file with the Department on July 1, 2004, for the hospital's fiscal year ending in 2002.
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3) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).

4) "Medicaid intensive care days" means, for a given hospital, the sum of days of inpatient hospital service for intensive care 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 the Act (Medicaid/Medicare crossover days), as contained in the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

5) "Total 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), as contained in the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

f) 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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.408 Trauma Center Adjustment Payments

a) Qualifying Criteria. Trauma Center 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 was a general acute care hospital that, as of January 1, 2005, was considered a trauma center and meets the requirements specified in subsection (c).

b) The following classes of hospitals are ineligible for Trauma Center Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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).

c) Trauma Center Adjustment Payments

1) Level I Trauma Center Adjustment Payments

   A) For an Illinois general acute care hospital that was considered a Level I trauma center as of January 1, 2005, that is located in a large urban area or another urban area that qualified for Medicaid Percentage Adjustments as described in Section 148.122 as of October 1, 2004, shall receive payments equal to the product of $800 multiplied by the qualifying hospital's Medicaid intensive care unit (ICU) days in the trauma base period.

      i) For a hospital located in a large urban area outside of a city with a population in excess of one million people, the Department shall pay an amount equal to the Level I Trauma Center Adjustment Payment calculated in subsection (c)(1)(A) of this Section multiplied by 4.5.

      ii) For a hospital located in another urban area, the Department shall pay an amount equal to the Level I Trauma Center Adjustment Payment calculated in (c)(1)(A) multiplied by 8.5.

2) Level II Trauma Center Adjustment Payments
A) For an Illinois general acute care hospital that was considered a Level II trauma center as of January 1, 2005 and is located in a county with a population in excess of three million people, the payment shall equal:

i) A hospital qualifying under subsection (c)(2)(A) of this Section shall be paid $4,000 per day for the first 500 Medicaid inpatient days in the trauma base period.

ii) A hospital qualifying under subsection (c)(2)(A) of this Section shall be paid $2,000 per day for the Medicaid inpatient days between 501 and 1,500 in the trauma base period.

iii) A hospital qualifying under subsection (c)(2)(A) of this Section shall be paid $100 per day for each Medicaid inpatient day over 1,500 in the trauma base period.

B) For an Illinois general acute care hospital that was considered a Level II trauma center as of January 1, 2005, and is located in a large urban area outside of a county with a population in excess of three million people and, as of January 1, 2005, was designated a Level III perinatal center or designated a Level II or II+ perinatal center that has a ratio of Medicaid ICU days to total Medicaid days greater than five percent, the payment shall equal:

i) A hospital qualifying under subsection (c)(2)(B) of this Section shall be paid $4,000 per day for the first 500 Medicaid inpatient days in the trauma base period.

ii) A hospital qualifying under subsection (c)(2)(B) of this Section shall be paid $2,000 per day for the Medicaid inpatient days between 501 and 1,500 in the trauma base period.

iii) A hospital qualifying under subsection (c)(2)(B) of this Section shall be paid $100 per day for each Medicaid inpatient day over 1,500 in the trauma base period.
3) Pediatric Trauma Center Adjustment Payments

A) Qualifying Criteria: Payment shall be for all Illinois children's hospitals designated as Level I pediatric trauma centers that provided more than 30,000 Medicaid days in State fiscal year 2003 and those out-of-state Level I pediatric trauma centers that provided more than 700 Illinois Medicaid admissions in State fiscal year 2003.

B) A hospital qualifying under subsection (c)(3)(A) of this Section shall receive payment equal to the product of $325 multiplied by the hospital's Illinois Medicaid ICU days.

C) For out-of-state hospitals qualifying under subsection (c)(3)(A), the amount calculated under subsection (c)(3)(B) shall be multiplied by 2.25.

4) A hospital that enrolled to provide Medicaid services during fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

5) Notwithstanding any other provisions of this subsection (c), a children's hospital as defined at 89 Ill. Adm. Code 149.49(c)(3)(b), is not eligible for the payments described in subsections (c)(1) and (c)(2) of this Section.

d) Payment to a Qualifying Hospital

1) For the trauma center adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) being met shall be paid within 100 days after the conditions described in subsection (f) of this Section have been met.

2) 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.
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e) Definitions

1) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).

2) "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), as contained in the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

3) "Medicaid intensive care unit days" means, for a given hospital, the number of hospital inpatient days during which Medicaid recipients received intensive care services from the hospital, as determined from the hospital's 2002 Medicaid cost report on file with the Department on July 1, 2004.

4) "Other urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a city with a population in excess of 50,000 or with a total population in excess of 100,000, and with an urban hospital as described in Section 148.25(g)(4).

5) "Trauma center adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

6) "Trauma center base period" means days reported in the hospital's 2002 Medicaid cost report on file with the Department on July 1, 2004.

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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.410 Psychiatric Rate Adjustment Payments

a) Qualifying Criteria. Psychiatric Rate Adjustment Payments described in subsection (b) of this Section shall be made to an Illinois psychiatric hospital and an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding the following hospitals:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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) Psychiatric Rate Adjustment Payments

1) For a hospital qualifying under subsection (a) of this Section, the Department shall pay an amount equal to $420 less the hospital's per diem rate for Medicaid inpatient psychiatric services, in effect on July 1, 2002, multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period. In no event, however, shall that amount be less than zero.

2) For a hospital qualifying under subsection (a) of this Section whose inpatient psychiatric per diem rate is greater than $420, the Department shall pay an amount equal to $40 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period.
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3) For an Illinois psychiatric hospital located in a county with a population in excess of three million people that did not qualify for Medicaid Percentage Adjustments, as described in Section 148.122, for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to $150 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period.

4) For an Illinois psychiatric hospital located in a county with a population in excess of three million people, but outside of a city with a population in excess of one million people, and did qualify for Medicaid Percentage Adjustments, as described in Section 148.122, for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to $20 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period.

c) Payment to a Qualifying Hospital

1) For the psychiatric rate adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

2) 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) "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, 2004.
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2) "Psychiatric rate adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Psychiatric rate base period" means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.

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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.412 Rehabilitation Adjustment Payments

a) Qualifying Criteria. Rehabilitation 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:

1) if it is an Illinois general acute-care hospital, as described in Section 148.270(c)(1), located in a large urban area, with a rehabilitation unit that has 40 rehabilitation beds or more based upon the 2003 Medicaid cost report on file with the Department as of March 31, 2005; or

2) if it is an Illinois rehabilitation hospital, as defined at 89 Ill. Adm. Code 149.50(c)(2), that did not qualify for Medicaid Percentage Adjustment Payments under Section 148.122 for the 12-month period beginning on October 1, 2004.

b) The following classes of hospitals are ineligible for Rehabilitation Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
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1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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).

c) Rehabilitation Adjustment Payments

1) For a hospital qualifying under subsection (a)(1) of this Section, the Department shall pay the product of $230 multiplied by the hospital's Medicaid inpatient days.

2) For a hospital qualifying under subsection (a)(2) of this Section, the Department shall pay an amount equal to the product of $200 multiplied by the hospital's Medicaid inpatient days.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the rehabilitation adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) 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
1) "Large urban area" means, an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).

2) "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), as tabulated from the Department's paid claims data for admissions occurring in the rehabilitation base period that was adjudicated by the Department through June 30, 2004.

3) "Rehabilitation adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

4) "Rehabilitation base period" means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.

f) 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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.414 Supplemental Tertiary Care Adjustment Payments

a) Qualifying Criteria. Supplemental Tertiary Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to all qualifying hospitals. An Illinois hospital shall qualify for payment if it was deemed eligible
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for payments under the Tertiary Care Adjustment Payments for fiscal year 2005, 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, 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 will be made to qualifying hospitals and will equal the product of the hospital's fiscal year 2005 tertiary care adjustment as described at Section 148.296 multiplied by 2.5.

c) Payment to a Qualifying Hospital

1) For the supplemental tertiary care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

2) 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) "Tertiary care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, means the 12-month period beginning July 1 of the year and ending June 30 of the following year.

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;
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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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.416 Crossover Percentage Adjustment Payments

a) Qualifying Criteria. Crossover Percentage Adjustment Payments shall be made to qualifying hospitals as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it is an Illinois general acute care hospital as described in Section 148.270(c)(1), excluding any hospital defined as a cancer center hospital, located in an urban area, that provided over 500 days of inpatient care to Medicaid recipients, that had a ratio of crossover days to total Medicaid days, utilizing information used for the Medicaid percentage adjustment determination described in Section 148.122, effective October 1, 2004, of greater than 40 percent and that did not qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 on October 1, 2004.

b) The following classes of hospitals are ineligible for Crossover Percentage Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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).

4) Cancer center hospitals.

c) Crossover Percentage Adjustment Payments

1) Each qualifying hospital's crossover days will be divided by its total Medicaid days to determine the crossover percentage ratio.
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2) Each hospital qualifying under subsection (a) of this Section, located in an other urban area as described in subsection (e)(5) of this Section, shall receive payment equal to $140 multiplied by the hospital's total Medicaid days (including Medicaid/Medicare crossovers).

3) Each hospital qualifying under subsection (a) of this Section located in a large urban area as described in subsection (e)(4) of this Section, with a crossover percentage less than 55 percent, shall receive payment equal to $350 multiplied by the hospital's total Medicaid days (including Medicaid/Medicare crossovers).

4) Each hospital qualifying under subsection (a) located in a large urban area as described in subsection (e)(4) of this Section, with a crossover percentage ratio equal to or greater than 55 percent, shall receive payment equal to $1,400 multiplied by the hospital's total Medicaid days (including Medicaid/Medicare crossovers).

5) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the crossover percentage adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) 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

1) "Cancer center hospital" means an Illinois hospital that has received the approval of the American College of Surgeons Commission on Cancer.
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of June 16, 2005 and provides more than 15 percent of the hospital Medicaid days in State fiscal year 2003 for treating patients with cancer. To be counted as cancer days, the Department will identify cancer days with any claim that contains an ICD-9-CM diagnosis code of 140.0 through 208.9 and 230.0 through 234.9 provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004. To determine if 15 percent of the hospital Medicaid days were for treating cancer patients, the cancer days will be divided by the total Medicaid days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004.

2) "Crossover percentage adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Crossover percentage base period" means the information utilized in the Medicaid percentage adjustment determination as described in Section 148.122 for October 1, 2004.

4) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).

5) "Other urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a city with a population greater than 50,000 or with a total population in excess of 100,000, and with an urban hospital as described in Section 148.25(g)(4).

6) "Total Medicaid days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance
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under Title XIX of the federal Social Security Act, including days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's Medicaid percentage adjustment determination as described in Section 148.122 for October 1, 2004.

f) 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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.418 Long Term Acute Care Hospital Adjustment Payments

a) Qualifying Criteria. Long Term Acute Care Hospital Adjustment Payments described in subsection (b) of this Section shall be made to an Illinois long term stay hospital, as defined in 89 Ill. Adm. Code 149.50(c)(4), excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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) Long Term Acute Care Hospital Adjustment Payments

1) For a hospital qualifying under subsection (a) of this Section that qualified for Medicaid Percentage Adjustment Payments under Section 148.122 for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to the product of $125 multiplied by Medicaid
inpatient days provided during the long term acute care hospital base period.

2) For a hospital qualifying under subsection (a) of this Section that did not qualify for Medicaid Percentage Adjustment Payments under Section 148.122 for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to the product of $1,250 multiplied by Medicaid inpatient days of care provided during the long term acute care hospital base period.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the long term acute care hospital adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

2) 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) "Long term acute care hospital adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

2) "Long term acute care hospital base period" means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.
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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 long term care hospital base period that was adjudicated by the Department through June 30, 2004.

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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.420 Obstetrical Care Adjustment Payments

a) Qualifying Criteria. Obstetrical Care Adjustment Payments shall be made to a qualifying Illinois hospital that provided obstetrical care in the obstetrical base period. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment for the rate year 2006 determination.

b) The following classes of hospitals are ineligible for Obstetrical Care Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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).
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c) Obstetrical Care Adjustment Payments

1) A hospital qualifying under subsection (a) of this Section shall receive payments equal to the product of $550 multiplied by the qualifying hospital's Medicaid obstetrical days provided during the obstetrical care base period.

2) A hospital qualifying under subsection (a) of this Section that qualified for disproportionate share payment adjustments as described in Section 148.120 as of October 1, 2004, with a Medicaid obstetrical percentage greater than ten percent and a Medicaid emergency care percentage greater than 40 percent, shall receive payments equal to the product of $650 multiplied by the qualifying hospital's Medicaid obstetrical days provided during the obstetrical care base period.

3) A hospital qualifying under subsection (a) of this Section located in the St. Louis metropolitan statistical area, with more than 500 Medicaid obstetrical days, shall receive payments equal to the product of $1,800 multiplied by the qualifying hospital's Medicaid obstetrical days provided during the obstetrical care base period.

4) A large urban hospital qualifying under subsection (a) of this Section that has a Medicaid obstetrical percentage greater than 25 percent and is in a county with an eligibility growth percentage rate greater than 60 percent between the years 1998 and 2003 shall receive payments equal to the product of $600 multiplied by the qualifying hospital's Medicaid obstetrical days provided within the obstetrical care base period.

5) A rural hospital as described in Section 148.25(g)(3) qualifying under subsection (a) designated as a Level II perinatal center as of January 1, 2005, with a MIUR greater than 34 percent in State fiscal year 2002 and a Medicaid obstetrical percentage greater than 15 percent, shall receive payment equal to the product of $400 multiplied by the hospital's Medicaid obstetrical days provided within the obstetrical care base period multiplied by 6.

6) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements
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annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the obstetrical care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) 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

1) "Emergency care percentage" means a fraction, the numerator of which is the total Category 3 ambulatory procedure listing services, excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2003 contained in the Department's data base adjudicated through June 30, 2004, and the denominator of which is the total ambulatory procedure listing services, excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2003 contained in the Department's data base adjudicated through June 30, 2004.

2) "Growth percentage" means, for a given hospital, the percentage of change in the growth of Medicaid clients within the county where the hospital is located from 1998 to 2003.

3) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000.

4) "Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance
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under Title XIX of the federal Social Security Act, with a Diagnosis Related Grouping (DRG) of 370 through 375, excluding days 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 obstetrical base period the Department adjudicated through June 30, 2004.

5) "Medicaid obstetrical percentage" means the percentage used in the October 1, 2004 Medicaid percentage adjustment determination as described in Section 148.122.

6) "Obstetrical care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

7) "Obstetrical care base period" means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.

f) 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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.422 Outpatient Access Payments

a) Qualifying Criteria. Outpatient Access Payments, as described in subsection (b) of this Section, shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital shall qualify for payment if it was assessed as described in 89 Ill. Adm. Code 140.80 for the rate year 2006 determination, excluding the following hospitals:
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1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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 Access Payments

1) Outpatient access payments shall be made to a hospital qualifying under subsection (a) of this Section. Payment will equal 2.38 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided in the outpatient access base period, multiplied by the change in the growth percentage of Medicaid clients within the hospital's county from State fiscal year 1998 to State fiscal year 2003.

2) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the outpatient access adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) have been met.

2) 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
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1) "Growth percentage" means, for a given hospital, the percentage of change in the growth of Medicaid clients within the county where the hospital is located from 1998 to 2003.

2) "Outpatient access adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Outpatient access base period" means the 12-month period beginning on July 1, 2002 and ending June 30, 2003.

4) "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), 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 access base period that were adjudicated by the Department through June 30, 2004.

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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.424 Outpatient Utilization Payments

a) Qualifying Criteria. Outpatient Utilization Payments, as described in subsection (b) of this Section, shall be made to an Illinois hospital, excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).
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2) Hospitals organized under the University of Illinois Hospital Act, 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 Utilization Adjustment Payments

1) A rural hospital, as described in Section 148.25(g)(3) and qualifying under subsection (a) of this Section shall receive an amount equal to 1.7 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided during the outpatient utilization adjustment base period.

2) An urban hospital, as described in Section 148.25(g)(4) and qualifying under subsection (a) of this Section shall receive an amount equal to 0.45 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided during the outpatient utilization adjustment base period.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the outpatient utilization adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) have been met.

2) 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
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1) "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 access base period that were adjudicated by the Department through June 30, 2004.

2) "Outpatient utilization adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Outpatient utilization base period" means the 12-month period beginning on July 1, 2002 and ending June 30, 2003.

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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.426 Outpatient Complexity of Care Adjustment Payments

a) Qualifying Criteria. Outpatient Complexity of Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to Illinois hospitals located in an urban area as described in Section 148.25(g)(4), excluding:

1) County-owned hospitals, as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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 Complexity of Care Adjustment Payments

1) Each hospital qualifying under subsection (a) of this Section will receive a payment equal to the product of 2.55, multiplied by the hospital's emergency care percentage, multiplied by the hospital's ambulatory procedure listing payments.

2) Each children's hospital qualifying under subsection (a) of this Section, with a Medicaid inpatient utilization rate greater than 90 percent used for the October 1, 2004 Medicaid percentage adjustment determination described in Section 148.122, shall have the adjustment, as calculated in subsection (b)(1), multiplied by 2.

3) Each cancer center hospital qualifying under subsection (a) of this Section shall have the adjustment, as calculated in (b)(1), multiplied by 3.

4) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the outpatient complexity of care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) have been met.

2) 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) "Cancer center hospital" means an Illinois hospital that has received the approval of the American College of Surgeons Commission on Cancer as of June 16, 2005 and provides more than 15 percent of the hospital Medicaid days in State fiscal year 2003 for treating patients with cancer. To be counted as cancer days, the Department will identify cancer days with any claim that contains an ICD-9-CM diagnosis code of 140.0 through 208.9 and 230.0 through 234.9 provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004. To determine if 15 percent of the hospital Medicaid days were for treating cancer patients, the cancer days will be divided by the total Medicaid days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004.

2) "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 2003 contained in the Department's data base adjudicated through June 30, 2004, 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 2003 contained in the Department's data base adjudicated through June 30, 2004.

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 complexity of care base period that were adjudicated by the Department through June 30, 2004.

4) "Outpatient complexity of care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and
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ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

5) "Outpatient complexity of care base period" means the 12-month period beginning on July 1, 2002 and ending June 30, 2003.

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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.428 Rehabilitation Hospital Adjustment Payments

a) Qualifying Criteria. Rehabilitation Hospital Adjustment Payments, as described in subsection (c) of this Section, shall be made to a qualifying Illinois freestanding rehabilitation hospital that did not qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 for the 12-month period beginning on October 1, 2004, if not otherwise excluded under subsection (b) of this Section.

b) The following classes of hospitals are ineligible for Rehabilitation Hospital Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in 89 Ill. Adm. Code 148.25(b)(6).
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c) Rehabilitation Hospital Adjustment Payments for hospitals qualifying under subsection (a) of this Section will receive an amount equal to three multiplied by the hospital's outpatient ambulatory procedure listing payments for Group 6A services provided during the rehabilitation hospital base period.

d) Payment to a Qualifying Hospital

1) For the rehabilitation hospital adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) 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

1) "Outpatient ambulatory procedure listing payments for Group 6A services" means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1)(F), 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 rehabilitation hospital base period that were adjudicated by the Department through June 30, 2004.

2) "Rehabilitation hospital adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Rehabilitation hospital base period" means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.

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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.430 Perinatal Outpatient Adjustment Payments

a) Qualifying Criteria. Perinatal Outpatient Adjustment Payments shall be made to qualifying Illinois general acute care hospitals that were designated as a perinatal center as of January 1, 2005. A hospital not otherwise excluded under subsection (b) of this Section for the perinatal outpatient adjustment period determination shall qualify for payment if the hospital:

1) Is located in a large urban area;

2) Has a Medicaid obstetrical percentage of at least ten percent used for the October 1, 2004 Medicaid percentage adjustment determination as described in Section 148.122;

3) Has a Medicaid intensive care unit percentage of at least three percent; and

4) Has a ratio of ambulatory procedure listing for total Group 3 services, described in Section 148.140(b)(1)(C), to total ambulatory procedure services, as described in Section 148.140(b)(1), of at least 50 percent.

b) The following classes of hospitals are ineligible for Perinatal Outpatient Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

c) Perinatal Outpatient Adjustment Payments

1) A hospital qualifying under subsection (a) of this Section shall receive payment equal to the product of $550 multiplied by the hospital's ambulatory procedure listing for emergency Level I services described in Section 148.140(b)(1)(C)(i) provided in the perinatal outpatient base period.

2) For a hospital that, as of January 1, 2005, was designated a Level II+ or III perinatal center qualifying under subsection (a) of this Section, the payment calculated in subsection (c)(1) will be multiplied by four.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the perinatal outpatient adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) 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

1) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated
February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).

2) "Medicaid intensive care unit percentage" means a fraction, the numerator of which is the number of hospital inpatient days during which Medicaid recipients received intensive care services from the hospital, as determined from the hospital's fiscal year 2002 Medicaid cost report on file with the Department as of July 1, 2004, and the denominator of which is 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), as contained in the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

3) "Outpatient ambulatory procedure listing emergency Level I services" means, for a given hospital, the sum of services for ambulatory procedure listing services as described in Section 148.140(b)(1)(C)(i), 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 perinatal outpatient base period that were adjudicated by the Department through June 30, 2004.

4) "Perinatal outpatient adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

5) "Perinatal outpatient base period" means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.

f) 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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

**Section 148.432 Supplemental Psychiatric Adjustment Payments**

a) Qualifying Criteria. Supplemental Psychiatric Adjustment Payments shall be made to a qualifying hospital as defined in this subsection (a). An Illinois hospital shall qualify for payment if it did not qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 for the 12-month period beginning October 1, 2004, but is eligible for psychiatric adjustment payments as described in Section 148.105 for fiscal year 2005, excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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 Psychiatric Adjustment Payments will be made to qualifying hospitals and will equal the product of the hospital's fiscal year 2005 Psychiatric Adjustment Payments, as described in Section 148.105, multiplied by 0.7.

c) Payment to a Qualifying Hospital

1) For the supplemental psychiatric adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 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 the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

2) 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) "Supplemental base rate adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section received 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: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.434 Outpatient Community Access Adjustment Payments

a) Qualifying Criteria. Outpatient Community Access Adjustment Payments, as described in subsection (b) of this Section, shall be made to an Illinois general acute care hospital as described in Section 148.270(c)(1) that was designated as a perinatal center as of January 1, 2005, that had a Medicaid obstetrical percentage used for the October 1, 2004 Medicaid percentage adjustment determination described in Section 148.122 of at least 12.5 percent, that had a ratio of crossover days to total Medicaid days greater than or equal to 25 percent, utilizing information used for the Medicaid Percentage Adjustment Payment described in Section 148.122, and that qualified for Medicaid Percentage Adjustment Payments as described in Section 148.122 on October 1, 2004, excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, 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 Community Access Adjustment Payments
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

1) Hospitals qualifying under subsection (a) of this Section shall receive an amount equal to $100 multiplied by the hospital's outpatient ambulatory procedure listing services in the outpatient community access base period.

2) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the outpatient community access adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

2) 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) "Outpatient ambulatory procedure listing services" means, for a given hospital, the sum of services 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 community access base period that were adjudicated by the Department through June 30, 2004.

2) "Outpatient community access adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12 month period beginning July 1 of the year and ending June 30 of the following year.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

3) "Outpatient community access base period" means the 12-month period beginning on July 1, 2002 and ending June 30, 2003.

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: Added at 30 Ill. Reg. 383, effective December 28, 2005)
DEPARTMENT OF NATURAL RESOURCES
NOTICE OF ADOPTED AMENDMENT

1) **Heading of the Part:** Ginseng Harvest and Commerce Regulations

2) **Code Citation:** 17 Ill. Adm. Code 1580

3) **Section Number:** 1580.35  
**Adopted Action:** New Section

4) **Statutory Authority:** Implementing and authorized by the Ginseng Harvesting Act [525 ILCS 20].

5) **Effective Date of Amendment:** January 3, 2006

6) **Does this amendment contain an automatic repeal date?** No

7) **Does this amendment contain incorporations by reference?** No

8) A copy of the adopted amendment, including all material incorporated by reference, is on file in the Department of Natural Resources's principal office and is available for public inspection.

9) **Notice of Proposal published in Illinois Register:** September 16, 2005; 29 Ill. Reg. 13975

10) **Has JCAR issued a Statement of Objection to this amendment?** No

11) **Differences between proposal and final version:** None

12) **Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR?** Yes

13) **Will this amendment replace an emergency rulemaking currently in effect?** No

14) **Are there any amendments pending on this Part?** No

15) **Summary and purpose of rulemaking:** This Part was amended to be in compliance with federal requirements. The U.S. Fish and Wildlife Service has determined their previous requirement that harvested wild American ginseng plants be at least 5 years of age is insufficient for the regeneration and population growth of the species needed to sustain the current harvest levels and ensure the long-term viability of the species. For the 2005 harvest season they have made the determination that it is necessary to increase the minimum age for exports of wild American ginseng from 5 years of age (3-leafed) to 10
years of age (4 leafed) or older. The amendment to this Part also requires harvesters to plant all of the seeds from harvested plants in the vicinity of the parent plants in a manner which will encourage their germination and growth.

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

Jack Price, Legal Counsel  
Department of Natural Resources  
One Natural Resources Way  
Springfield IL  62702-1271  
217/782-1809

The full text of the Adopted Amendment begins on the next page:
DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED AMENDMENT

TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF NATURAL RESOURCES
SUBCHAPTER d: FORESTRY

PART 1580
GINSENG HARVEST AND COMMERCE REGULATIONS

Section 1580.35  Harvest Regulations for Wild Ginseng

a) The harvest of wild ginseng shall be limited to plants that are 10 years of age (4 leafed) or older.

b) When harvesting wild ginseng, harvesters shall plant all of the seeds from the harvested plants in the vicinity of the parent plants in a manner that will encourage their germination and growth.

(Source: Added at 30 Ill. Reg. 458, effective January 3, 2006)
DEPARTMENT OF NATURAL RESOURCES
NOTICE OF ADOPTED RULES

1) **Heading of the Part:** Illinois Resident Armed Forces Fee Exemptions

2) **Code Citation:** 17 Ill. Adm. Code 2510

3) **Section Numbers:**

   - 2510.10  New Section
   - 2510.20  New Section
   - 2510.30  New Section
   - 2510.40  New Section
   - 2510.50  New Section

4) **Statutory Authority:** Implementing and authorized by Sections 805-305 of the Civil Administrative Code of Illinois [20 ILCS 805/805-305], Sections 20-47 of the Fish and Aquatic Life Code [515 ILCS 5/20-47] and by Section 3.1-4 of the Wildlife Code [520 ILCS 5/3.1-4].

5) **Effective Date of Rules:** January 3, 2006

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 all material incorporated by reference, is on file in the Department of Natural Resource's principal office and is available for public inspection.

9) **Notice of Proposal published in Illinois Register:** September 23, 2005; 29 Ill. Reg. 14164

10) **Has JCAR issued a Statement of Objection to these rules?** No

11) **Differences between proposal and final version:**

   - Section 2510.30 – added a comma following "mobilized"
   - Section 2510.40(b)(2) – replaced "of" with "after"
   - Section 2510.40(d) – in two places added "Combined" prior to "Sportsman's"
   - Section 2510.50(a) changed citation to read "(see 520 ILCS 5/3.5)"
DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED RULES

Section 2510.50(b) – changed citation to read "(see 720 ILCS 5/16-1)"

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? Yes

2510.10 New Section 9/23/05, 29 Ill. Reg. 14396
2510.20 New Section 9/23/05, 29 Ill. Reg. 14396
2510.30 New Section 9/23/05, 29 Ill. Reg. 14396
2510.40 New Section 9/23/05, 29 Ill. Reg. 14396
2510.50 New Section 9/23/05, 29 Ill. Reg. 14396

14) Are there any rules pending on this Part? No

15) Summary and purpose of rulemaking: Public Act 94-0313, effective July 25, 2005, amended the Civil Administrative Code of Illinois, the Fish and Aquatic Life Code and the Wildlife Code, to add provisions for Illinois resident military members who have served abroad, or guard or reserve members called to active duty, to receive free camping, hunting and fishing permits. This rule contains criteria for qualifying military members, including information on free privileges available and application requirements.

16) Information and questions regarding these adopted rules shall be directed to:

       Jack Price, Legal Counsel
       Department of Natural Resources
       One Natural Resources Way
       Springfield IL  62702-1271

       217/782-1809

The full text of the Adopted Rules begins on the next page:
DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED RULES

TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF NATURAL RESOURCES
SUBCHAPTER f: ADMINISTRATIVE SERVICES

PART 2510
ILLINOIS RESIDENT ARMED FORCES FEE EXEMPTIONS

Section 2510.10 Purpose
The purpose of this Part is to acknowledge the contribution of Illinois residents returning from service abroad or mobilization by the President of the United States as an active duty member of the United States Armed Forces, the Illinois National Guard, or the Reserves of the United States Armed Forces [20 ILCS 805/805-305]. In recognition of their services, the Department of Natural Resources will waive specified fees for camping, fishing and hunting for the amount of time that the active duty member spent in service abroad or mobilized.

Section 2510.20 Definitions
Active Duty – means active duty in the Armed Forces of the United States, as evidenced by a DD form 2, United States Uniformed Service Identification Card, marked "Active" or "Active Duty".

Department – means the Department of Natural Resources.

Members – means Illinois resident military, guard or reserve members.
Mobilization – means that Reserves or Guard Members were called to active duty by the President of the United States under Title 10 or Title 32, United States Code.

Service Abroad – means active duty service outside the states of the United States of America, its territories or possessions.

Verification of Service Abroad or Verification of Mobilization – means official documentation from the Department of Defense or the appropriate major command showing mobilization dates or service abroad dates. Acceptable documents include a DD-214; a letter from the Illinois Department of Military Affairs for members of the Illinois National Guard, the Regional Reserve Command for members of the Armed Forces Reserve, the Major Command covering Illinois for active duty members; or personnel records for State employees mobilized. A copy of orders shall not be accepted as verification.

**Section 2510.30 Fee Exemptions**

a) Illinois resident military members who have served abroad, or guard or reserve members who were mobilized, are eligible for the following without fee:

1) Camping, with no camping fee except:
   
   A) camper is responsible for applicable utility fees; and
   
   B) camper is responsible for applicable rent-a-tent fees and cabin fees.

2) Sport fishing and hunting:
   
   A) Members will be issued a current Combined Sportsman's License and Habitat Stamp.
   
   B) If requested by the member, one statewide archery deer permit will be issued upon verification if currently available. One free firearm deer permit for the county of choice (and the archery deer permit if not available at time of verification) will be mailed to the applicant when available.

b) Non-resident military members are not eligible for no-fee hunting, fishing or camping.
Section 2510.40 Application

a) Military members are eligible for free sport fishing, hunting and camping for one year for each year served and for one year for each portion of a year served.

b) To receive a camping pass, sportsman's license, habitat stamp and/or deer permit, eligible military members shall:

1) Appear in person at the Department of Natural Resources headquarters:

   Illinois Department of Natural Resources
   One Natural Resources Way
   Springfield, Illinois

2) Apply within two years after their return from abroad or release from mobilization. Members released or who returned anytime in 2003 must apply before December 31, 2005.

3) Provide verification of dates of service abroad or verification of dates of mobilization (see Section 2510.20).

4) Provide a photo identification card.

c) The Armed Forces Special Pass (camping) shall become effective on the date of application and shall expire on the same month and day in the year the entitlement expires.

d) The Combined Sportsman's License will expire March 31 of each year. A new Combined Sportsman's License, stamp and deer permit may be obtained by following the procedures under subsection (b) or by showing an unexpired Armed Forces Special Pass.

Section 2510.50 Violations

a) Violation of this Part is a petty offense (see 520 ILCS 5/3.5).

b) Obtaining licenses, stamps, permits or an Armed Forces Special Pass (camping) by providing false information is a Class 4 Felony (see 720 ILCS 5/16-1).
c) Misuse of the Armed Forces Special Pass, such as obtaining a campsite for others for times the member does not camp at the site, shall result in forfeiture of the pass, in addition to other penalties prescribed by law.
DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED AMENDMENT

1) **Heading of the Part**: Off-Highway Vehicle Recreational Trails Grant Program

2) **Code Citation**: 17 Ill. Adm. Code 3045

3) **Section Number**: Adopted Action:
   - 3045.95 New Section

4) **Statutory Authority**: Implementing and authorized by Section 15 of the Recreational Trails of Illinois Act [20 ILCS 862/15]

5) **Effective Date of Amendment**: January 3, 2006

6) **Does this amendment contain an automatic repeal date?** No

7) **Does this amendment contain incorporations by reference?** No

8) A copy of the adopted amendment, including all material incorporated by reference, is on file in the Department of Natural Resource's principal office and is available for public inspection.

9) **Notice of Proposal published in Illinois Register**: September 16, 2005; 29 Ill. Reg. 13978

10) **Has JCAR issued a Statement of Objection to this amendment?** No

11) **Differences between proposal and final version**: None

12) **Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR?** Yes

13) **Will this amendment replace an emergency rulemaking currently in effect?** No

14) **Are there any amendments pending on this Part?** No

15) **Summary and purpose of rulemaking**: This Part was amended to add a Section pertaining to the sale or transfer of grant-funded property. This Section contains formulas for repayment of grants for land purchased partially and wholly, if the property is sold in under 15 years from receipt of the grant.

16) **Information and questions regarding this adopted amendment shall be directed to:**
DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED AMENDMENT

Jack Price, Legal Counsel
Department of Natural Resources
One Natural Resources Way
Springfield IL  62702-1271

217/782-1809

The full text of the Adopted Amendment begins on the next page:
Section 3045.95  Sale or Transfer of Grant-Funded Property

   a)  Real Property

      1)  If land purchased wholly by grant funds is sold or transferred by operation of law other than transfer due to the death of the grantee:

              A)  within 5 years after receipt of grant funds, 100% of the grant funding or of the sale price, whichever is greater, must be paid back to the OHV grant fund;
DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED AMENDMENT

B) in the 6th year after receipt of grant funds, 90% of the grant funding or 90% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

C) in the 7th year after receipt of grant funds, 80% of the grant funding or 80% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

D) in the 8th year after receipt of grant funds, 70% of the grant funding or 70% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

E) in the 9th year after receipt of grant funds, 60% of the grant funding or 60% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

F) in the 10th year after receipt of grant funds, 50% of the grant funding or 50% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

G) in the 11th year after receipt of grant funds, 40% of the grant funding or 40% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

H) in the 12th year after receipt of grant funds, 30% of the grant funding or 30% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

I) in the 13th year after receipt of grant funds, 20% of the grant funding or 20% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

J) in the 14th year after receipt of grant funds, 10% of the grant funding or 10% of the sale price, whichever is greater, must be paid back to the OHV grant fund; and

K) in the 15th year or thereafter, no reimbursement to the OHV grant fund is required.
DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED AMENDMENT

2) If land purchased partially by grant funds is sold or transferred by operation of law other than transfer due to the death of the grantee:

A) within 5 years after receipt of grant funds, 100% of the grant funding or 100% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

B) in the 6th, 7th or 8th year after receipt of grant funds, 80% of the grant funding or 80% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

C) in the 9th, 10th or 11th year after receipt of grant funds, 60% of the grant funding or 60% of the sale price, whichever is greater, must be paid back to the OHV grant fund;

D) in the 12th, 13th or 14th year after receipt of grant funds, 30% of the grant funding or 30% of the sale price, whichever is greater, must be paid back to the OHV grant fund; and

E) in the 15th year or thereafter, no reimbursement to the grant fund is required.

b) Personal Property

1) No personal property purchased with grant funds shall be disposed of without the Department's written consent, which shall not be unreasonably withheld. Disposing of such property without written consent shall require repayment of the grant funding used to purchase the property or the fair market value of the property, whichever is deemed most appropriate by the Department.

2) Any insurance proceeds from personal property that was purchased with grant funds and is accidentally destroyed must be used to replace the destroyed personal property, unless the Department concurs in writing that the insurance proceeds may be used for another purpose.

(Source: Added at 30 Ill. Reg. 467, effective January 3, 2006)
1) **Heading of the Part:** The Administration and Operation of the Teachers' Retirement System

2) **Code Citation:** 80 Ill. Adm. Code 1650

3) **Section Number:** 1650.201  
   **Adopted Action:** Amendment

4) **Statutory Authority:** Implementing and authorized by Article 16 of the Illinois Pension Code [40 ILCS 5/16]

5) **Effective Date of Amendment:** December 21, 2005.

6) **Does this rulemaking contain an automatic repeal date?** No

7) **Does this amendment contain incorporations by reference?** No

8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) **Notice of Proposal Published in Illinois Register:** May 20, 2005; 29 Ill. Reg. 7202

10) **Has JCAR issued a Statement of Objection to this rulemaking?** No

11) **Differences between proposal and final version:** Various punctuation changes recommended by JCAR were made in the final version.

12) **Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR?** Yes

13) **Will this rulemaking replace any emergency rulemaking currently in effect?** No

14) **Are there any amendments pending on this Part?** No

15) **Summary and Purpose of Amendment:** This amendment clarifies that if a member fails to submit all required medical documentation to perfect a disability or occupational disability claim within 6 months after his or her written notification of disability, benefits will not become payable until the date all such required documentation is submitted to the System.
TEACHERS RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

NOTICE OF ADOPTED AMENDMENT

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

Thomas S. Gray, General Counsel
Teachers’ Retirement System
2815 West Washington
Springfield, Illinois  62794-9253

(217) 753-0375

The full text of the Adopted Amendment begins on the next page:
TEACHERS RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

NOTICE OF ADOPTED AMENDMENT

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE D: RETIREMENT SYSTEMS
CHAPTER III: TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

PART 1650
THE ADMINISTRATION AND OPERATION OF THE TEACHERS' RETIREMENT SYSTEM

SUBPART A: REPORTS BY BOARD OF TRUSTEES

Section 1650.10 Annual Financial Report (Repealed)

SUBPART B: BASIC RECORDS AND ACCOUNTS

Section 1650.110 Membership Records
1650.120 Claims Records (Repealed)
1650.130 Individual Accounts (Repealed)
1650.140 Ledger and Accounts Books (Repealed)
1650.150 Statistics (Repealed)
1650.160 Confidentiality of Records
1650.180 Filing and Payment Requirements
1650.181 Early Retirement Incentive Payment Requirements
1650.182 Waiver of Additional Amounts Due
1650.183 Definition of Employer's Normal Cost

SUBPART C: FILING OF CLAIMS

Section 1650.201 Disability Benefits – Application Procedure
1650.202 Disability and Occupational Disability Benefits – Definitions
1650.203 Disability Retirement Annuity – Definitions
1650.204 Gainful Employment – Consequences
1650.205 Medical Examinations and Investigation of Disability Claims
1650.206 Physician Certificates
1650.207 Disability Due to Pregnancy
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TEACHERS RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

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SUBPART O: RETIRMENT BENEFITS
TEACHERS RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

NOTICE OF ADOPTED AMENDMENT

Section
1650.2900 Excess Benefit Arrangement

AUTHORITY: Implementing and authorized by Articles 1 and 16 of the Illinois Pension Code [40 ILCS 5/Arts. 1 and 16]; Freedom of Information Act [5 ILCS 140]; Internal Revenue Code (26 USC 1 et seq.); Section 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-15].


SUBPART C: FILING OF CLAIMS

Section 1650.201 Disability Benefits – Application Procedure

a) Any individual claiming a disability benefit under 40 ILCS 5/16-149, 16-149.1 or
16-149.2 shall begin the process by filing a written notice with the System by letter or telefax.

b) For purposes of 40 ILCS 5/16-149 and 16-149.1, if a member files his or her written notice of disability within 90 days after the commencement of disability or the date eligibility for salary ceases, benefits shall be payable from the date the disability commenced or eligibility for salary ceased.

c) For purposes of 40 ILCS 5/16-149 and 16-149.1, if a member files his or her written notice of disability later than 90 days from the commencement of disability or the date eligibility for salary ceases, benefits may be payable from the member's date of application subject to provisions of subsection (d)(3).

d) Disability benefits under the provisions of 40 ILCS 5/16-149 shall become payable the later of:

1) the 31st calendar day the member is absent from teaching due to the disability for which benefits are sought;

2) upon exhaustion of the member's sick leave, or if sick leave is not paid by the employer, the date upon which the sick leave would have been exhausted had the member been paid by the employer;

3) the date the System receives written notification of disability if more than 90 days have elapsed from the later of:

   A) commencement of disability; or

   B) the last day for which salary is payable including payment for sick leave days, whether or not the sick leave days are actually paid for by the employer; or

4) the date on which all documentation required under 40 ILCS 5/16-149 is received by the System, if the receipt of the documentation is more than six months after the date notice is filed pursuant to subsection (a).

e) Occupational disability benefits under the provisions of 40 ILCS 5/16-149.1 shall become payable from the later of:

1) the date after the last day for which salary is paid; or
TEACHERS RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

NOTICE OF ADOPTED AMENDMENT

2) The date the System receives written notification of disability if more than 90 days have elapsed from the later of:

A) the commencement of the disability; or

B) the last day for which salary is paid; or

3) The date on which all documentation required under 40 ILCS 5/16-149 is received by the System, if the receipt of the documentation is more than six months after the date notice is filed pursuant to subsection (a).

f) When an individual claiming disability benefits is employed under an agreement for less than 12 full months, neither the 31-day waiting period nor the utilization of sick leave requirement, as contained in subsection (d) above, is satisfied during periods not covered by the agreement. For purposes of granting disability benefits, it will be presumed that all employment agreements cover one full school term and are automatically renewable at the commencement of the next school term. Satisfactory evidence must be presented of an employment agreement covering a longer period than a full school term (e.g., 10, 11 or 12 months).

g) Whenever a member becomes ineligible to receive a disability or occupational disability benefit due to gainful employment but is subsequently disabled for the same cause within 90 days after the member's or annuitant's last date of eligibility for benefits, benefits shall be reinstated at the previous benefit rate upon written application. Benefits shall commence the day following the last day the member is eligible to receive salary. If more than 90 days have elapsed, benefits shall be reinstated based on the greater of the member's most recent annual contract salary rate at the time the disability benefit becomes payable or the member's annual contract rate on the date the disability commenced.

(Source: Amended at 30 Ill. Reg. 472, effective December 21, 2005)
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

1) **Heading of the Part:** Illinois Cares Rx Program

2) **Code Citation:** 89 Ill. Adm. Code 119

3) **Section Numbers:**

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4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13], Public Act 94-86 and Public Act 94-48

5) **Effective Date:** January 1, 2006

6) **If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire:** Not Applicable

7) **Date Filed with the Index Department:** December 30, 2005

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:** These emergency amendments are being filed pursuant to the State’s budget implementation plan for fiscal year 2006 under Public Act 94-86. The Illinois Cares Rx Program, effective January 1, 2006, is a new program providing pharmaceutical assistance to eligible seniors and individuals with disabilities and will provide coverage for specified prescription drugs. Illinois Cares Rx replaces SeniorCare and Circuit Breaker Pharmaceutical Assistance and will result in a cost savings to the
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

State. Section 5-45 of Public Act 94-48 specifically authorizes emergency rulemaking for the implementation of these changes for fiscal year 2006.

10) Complete Description of the Subjects and Issues Involved: These emergency amendments respond to Public Act 94-86 under which the Illinois Cares Rx Program is established, effective January 1, 2006. This new program provides pharmaceutical assistance to eligible seniors and individuals with disabilities and will provide coverage for specified prescription drugs. The program provides benefits for individuals who are eligible for Medicare Part D and drug coverage for those who are not eligible for Medicare Part D. Illinois Cares Rx replaces SeniorCare and Circuit Breaker Pharmaceutical Assistance. Absent Illinois Cares Rx, eligible individuals would be responsible for significantly higher levels of cost-sharing than they had previously experienced under Circuit Breaker and SeniorCare.

The transition of seniors to Medicare Part D and Illinois Cares Rx is expected to result in a total savings of approximately $26.3 million.

11) Are there any other amendments pending on this Part? No

12) Statement of Statewide Policy Objectives: These emergency amendments neither create nor expand any State mandate affecting units of local government.

13) Information and questions regarding this amendment shall be directed to:

Joanne Scattoloni
Office of the General Counsel, Rules Section
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, Third Floor
Springfield, Illinois 62763-0002

(217) 524-0081

The full text of the Emergency Amendments 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 b: ASSISTANCE PROGRAMS

PART 119

ILLINOIS CARES RX PROGRAM
PHARMACEUTICAL ASSISTANCE PROGRAM

Section
119.10 Definitions
Purpose of the Pharmaceutical Assistance Program

119.20 Eligibility
Definitions

119.30 Low Income Subsidy
Covered Prescription Drugs

119.40 Automatic Enrollment of Program Beneficiaries

119.50 Assignment and Coordination of Benefits
Fees and Co-Payments

119.60 Covered Services
Determination of Cost of Covered Prescription Drugs

119.70 Prior Authorization and Preferred Drug List (PDL)
Authorized Pharmacy Qualifications

119.80 Illinois Cares Rx Basic Covered Prescription Drugs
Assignment and Coordination of Benefits

119.90 Co-Payments and Cost Sharing
Payments to Authorized Pharmacies

119.100 Pharmacy Payment
Execution of Contracts

119.110 Inspection and Disclosure of Records
Limitation on Prescription Size

119.120 Establishment of Liens
Inspection and Disclosure of Records

119.130 Penalties
Establishment of Liens

119.140 Penalties (Repealed)
NOTICE OF EMERGENCY AMENDMENTS


SOURCE: Adopted by emergency rulemaking at 28 Ill. Reg. 13816, effective October 1, 2004, for a maximum of 150 days; adopted at 29 Ill. Reg. 4069, effective February 25, 2005; emergency amendment at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days.

Section 119.10 Definitions Purpose of the Pharmaceutical Assistance Program

The following definitions apply for purposes of this Part:

"Act" means the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act [320 ILCS 25].

"Applicant" means any person in a household who has requested pharmaceutical assistance benefits on an application filed by an applicant.

"Beneficiary" means a person whose application for pharmaceutical assistance benefits under the Act has been approved by the Department on Aging.

"Brand name drug" means those drugs as defined in 89 Ill. Adm. Code 140.440(g)(3) when dispensed to an individual not enrolled in Medicare Part D. When dispensed to an individual enrolled in Medicare Part D, brand name drugs means those legend drugs defined as brand name drugs by the individual's Medicare Prescription Drug Plan (PDP).

"Coordinating Prescription Drug Plan" means a Medicare Part D Prescription Drug Plan that has signed a coordination agreement with the Department and to which the Department pays a per member/per month (PM/PM) payment for each Illinois Cares Rx beneficiary that the Department has assigned to that Plan.

"Department" means the Illinois Department of Healthcare and Family Services.

"Director" means the Director of the Illinois Department of Healthcare and Family Services.
"Disabled person" means a person who is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. [320 ILCS 25/3.14]

"Disease" means a chronic and possibly recurrent illness of long duration, as distinguished from an acute illness that is of short duration with recovery due to limited medical treatment (such as in the case of colds, flu, pneumonia, bronchitis, or other similar illnesses).

"Domiciled" means having a fixed habitation at a permanent residence in Illinois at the time of filing the application and during the coverage year.


"FPL" means the federal poverty income guideline as determined annually by the United States Department of Health and Human Services.

"Generic drug" means those legend drugs as defined in 89 Ill. Adm. Code 140.440(g)(2) when dispensed to individuals not enrolled in Medicare Part D. When dispensed to individuals enrolled in Medicare Part D, generic drugs means those legend drugs defined as generic drugs by the individual's Medicare Prescription Drug Plan (PDP).

"Household" means an applicant or an applicant and his or her spouse living together in the same residence. [320 ILCS 25/3.05]

"Household income" means the combined income of the members of a household for a year. [320 ILCS 25/3.06]

"Illinois Cares Rx Plus" means the provision of benefits to individuals in eligibility groups 3 or 4 as defined in 320 ILCS 25/4(g).

"Illinois Cares Rx Basic" means the provision of benefits to individuals in eligibility groups 1 or 2 as defined in 320 ILCS 25/4(g).
"Illinois Cares Rx Basic Covered Prescription Drug" means any drug included in the categories listed in Section 119.80 and prescribed as set forth in Section 119.80.

"Illinois Cares Rx Rebate" means an Illinois Cares Rx benefit in the form of a monetary payment (a monthly payment of $25) made to an individual enrolled in a third-party plan that provides a pharmacy benefit or a PDP that is not a Coordinating Medicare PDP. The payment is made in lieu of the covered services described in Section 119.60.

"Income" means adjusted gross income, properly reportable for federal income tax purposes under the provisions of the Internal Revenue Code, modified as defined in 320 ILCS 25/3.07.

"Non-Preferred Drug" means those drugs that are 3rd tier or higher on an individual's Medicare Part D Prescription Drug Plan's (PDPs) formulary or the Department's Preferred Drug List.

"Over-the-counter items" means those pharmaceutical items that may be purchased off the shelf by the general public.

"Pharmaceutical product" means a brand name drug, a generic drug, or an over-the-counter item.

"Prescription Drug Plan" or "PDP" means a Medicare Part D Prescription Drug Plan.

"Program" means the Illinois Cares Rx Pharmaceutical Assistance Program provided for under the Act.

"Projected income" means household income expected to be received for a coverage year.

The Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act (Act) [320 ILCS 25] provides for the establishment of a program of pharmaceutical assistance to be administered by the Department of Revenue. Executive Order 2004-3 transfers this Program to the Department on Aging and Department of Public Aid, effective July 1, 2004. The purpose for this program is to enable low-income senior citizens and disabled persons to afford medication for the treatment of heart disease and its related conditions, diabetes and arthritis; and, beginning January 1, 2001, cancer, Alzheimer's disease, Parkinson's disease,
Illinois Cares Rx Eligibility Qualifications
To be eligible for Illinois Cares Rx pharmaceutical benefits, an individual must meet all of the following requirements:

1) Be:
   A) 65 years of age or older; or
   B) a disabled person.

2) Be domiciled in Illinois at the time of filing an application, and during the coverage period.

3) Except for individuals choosing Illinois Cares Rx Rebate, enroll with a Coordinating Medicare Part D Prescription Drug Plan if eligible for Medicare Part D.

4) Except for individuals choosing Illinois Cares Rx Rebate, apply for all available subsidies under Medicare Part D. The Department may deem individuals to be compliant with this requirement in cases where the Department's data clearly indicates the individual would not be eligible for any low income subsidy.

5) Have a maximum household income as described in subsection (a)(5)(A), (B) or (C). If any income eligibility limit set forth in subsection (a)(5)(A), (B) or (C) is less than 200 percent of the Federal Poverty Level (FPL) for any year, the income eligibility limit for that year for households of that size shall be income equal to or less than 200 percent of the Federal Poverty Level.

   A) less than $21,218 for a household containing one person;
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B) less than $28,480 for a household containing two persons; or

C) less than $35,740 for a household containing three or more persons.

6) Individuals eligible for SeniorCare on December 31, 2005, will be automatically determined eligible for and enrolled in Illinois Cares Rx Plus for coverage year 2006; individuals eligible for Circuit Breaker Pharmaceutical Assistance on December 31, 2005, will be automatically determined eligible for and enrolled in Illinois Cares Rx Basic for coverage year 2006.

b) Illinois Cares Rx Plus Eligibility Qualifications
To be eligible for Illinois Cares Rx Plus pharmaceutical benefits as described in Section 119.60(a), an individual must meet all of the eligibility requirements described in subsection (a), and meet all of the following requirements:

1) Be a U.S. citizen or qualify as an eligible non-citizen pursuant to 89 Ill. Adm. Code 120.310.

2) Be 65 years of age or older.

3) Have countable annual income at or below 200 percent of the Federal Poverty Level guidelines published annually by the U.S. Department of Health and Human Services.

c) Proof of Eligibility Qualifications
An applicant must submit proof of his or her eligibility qualifications as described in subsections (a) and (b).

1) Examples of proof of date of birth include:

A) a baptismal record; or

B) a birth certificate; or

C) a driver's license; or

D) an identification card from the Secretary of State's office; or
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E) an insurance policy; or

F) naturalization papers.

2) Examples of proof of disability include:

A) proof that an applicant is eligible to receive disability benefits under the federal Social Security Act of 1935 (see 42 USC 423); or

B) issuance of an Illinois Disabled Person Identification Card stating that an applicant is under a Class 2 disability, as defined in Section 4A of the Illinois Identification Card Act [15 ILCS 335/4A]; or

C) status of an applicant as a disabled person determined by a physician designated by the Department using the same standards as used by the Social Security Administration with the costs of any required examination paid by the applicant (see 42 USC 423); or

D) receipt by an applicant of Railroad (see 45 USC 231), Civil Service, or Veterans' total disability benefits (see 38 USC 101). (See 320 ILCS 25/3.14.)

d) Income
Income shall be based on income for the full calendar year prior to the year the applicant filed an application for pharmaceutical benefits, unless the applicant requests consideration of projected income as described in subsections (d)(1)(A), (B), (C), (D) and (E).

1) Projected Income

A) An applicant may request that projected income for the coverage year be used as current income in determining eligibility at the time an application is filed if projected income for the coverage year will be lower than current income for the coverage year. The application must include an itemized listing of current income for the coverage year and projected income for the coverage year, together with documentation for the lost sources of income used in calculating projected income. The Department will allow such a request and use projected income as current income in processing


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the application if its use will enable an applicant to qualify for this program.

B) An applicant whose application has been denied for exceeding maximum household income eligibility qualifications may file an amended application requesting use of projected income for the coverage year as current income for the coverage year in re-determining eligibility if projected income for the coverage year will be lower than current income for the coverage year. The amended application must include an itemized listing of current income for the coverage year and projected income for the coverage year, together with documentation for the lost sources of income used in calculating projected income. The Department will allow such a request and use projected income as current income in processing the amended application if its use will enable an applicant to qualify for this program.

C) A beneficiary whose application has been approved for Illinois Cares Rx Basic may file an amended application requesting use of projected income for the coverage year as current income for the coverage year in redetermining the eligibility for Illinois Cares Rx Plus if projected income for the coverage year will be lower than current income for the coverage year. The amended application must include an itemized listing of current income for the coverage year and projected income for the coverage year, together with documentation for the lost sources of income used in calculating projected income. The Department will allow such a request and use projected income as current income in processing the amended application if its use will enable a beneficiary to qualify for Illinois Cares Rx Plus.

D) Amended applications for pharmaceutical assistance benefits must be filed on the appropriate paper forms approved by the Department prior to the expiration of the coverage year for the coverage year at issue.

E) A beneficiary may not use projected income for two consecutive years.

2) **Countable Income**
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The earned and unearned income of the applicant and his or her spouse (if the spouse resides with the applicant) shall be counted when determining eligibility.

3) Assets shall not be considered.

4) Illinois Cares Rx Plus participants shall be exempt from the requirements of 89 Ill. Adm. Code 102.210, Estate Claims, with regard to expenditures made for Illinois Cares Rx benefits.

e) An individual who is eligible for medical assistance with a spenddown may participate in Illinois Cares Rx.

f) An individual who receives benefits from any of the Medicare Savings programs (QMB, SLIB, or QI) may participate in Illinois Cares Rx.

g) Application Process

1) An application for pharmaceutical assistance benefits under the Act must be filed on the appropriate paper or electronic forms approved by the Department on Aging.

2) Individuals shall apply by completing and submitting an application as specified by the Illinois Department on Aging.

3) Spouses may apply on the same application as long as the application contains both signatures.

4) After eligibility is determined by the Illinois Department on Aging, notice of the outcome shall be sent to the applicant.

5) An individual enrolled in Illinois Cares Rx shall receive coverage under his or her own name and unique Recipient Identification Number.

h) Enrollment Periods

1) Enrollment shall be effective the first of the month no later than the second month after the date when the applicant was determined to be eligible for the program.
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2) The initial coverage period shall continue from the effective date of the enrollment through the end of the calendar year following the year in which the beneficiary filed the application for Illinois Cares Rx benefits.

3) Individuals must reapply annually.

4) Subsequent uninterrupted periods of enrollment shall be for 12 months and shall be coincident with the calendar year.

i) Authorization of Illinois Cares Rx
   Once an individual has been determined eligible for Illinois Cares Rx, an Illinois Cares Rx identification card shall be sent to the individual, unless the individual elects to participate in the Illinois Cares Rx Rebate Program.

j) Illinois Cares Rx coverage shall terminate:
   1) at the end of a participant's coverage period unless the participant reapplies timely and is found to continue to be eligible;
   2) when a participant no longer resides in Illinois;
   3) when a participant becomes an inmate of a public institution as set forth in 42 CFR 435.1008;
   4) upon a participant's death;
   5) upon discovery that the initial determination of the participant's eligibility was incorrect; or
   6) when a participant fails to apply for any low income subsidy available under Medicare Part D, except in cases where the Department has deemed the individual to be compliant based on the Department's data.

k) Appeals Rights
   Any applicant or beneficiary aggrieved by action of the Department under the Act, whether in the denial of an application or amended application may request in writing that the Department reconsider its action, setting out the facts on which the request is based. The Department will consider the request and either affirm or modify its action.
The following definitions apply to the terms used in this Part:

"Act" means the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act [320 ILCS 25].

"Additional resident" means any person who is not filing a separate claim for the same claim year under this Act and who is living in the same residence with a claimant and for whom the household has provided more than half of that person's total financial support for a claim year.

"Applicant" means a claimant, any person in a household who has requested pharmaceutical assistance benefits on a claim filed by a claimant and any additional resident who would become a beneficiary if the claim is approved by the Department on Aging.

"Beneficiary" means a person whose claim for pharmaceutical assistance benefits under the Act has been approved by the Department on Aging.

"Card" means an identification card issued to a Beneficiary by the Department of Revenue prior to January 1, 2001, and a Pharmaceutical Assistance Card issued to a Beneficiary by the Department of Revenue on and after January 1, 2001 and a Pharmaceutical Assistance Card issued to a Beneficiary by the Department on Aging on and after July 1, 2004.

"Claim" means an original paper application (Form No. IL-1363, possibly using Schedule A, Schedule B, and/or Schedule P), an amended paper application (Form No. IL-1363-X), or an electronic application filed by a verified Internet Filer for pharmaceutical assistance benefits under the Act.

"Claimant" means a person who has filed a claim for pharmaceutical assistance benefits under the Act [320 ILCS 25/3.01].

"Claim year" means the calendar year prior to the year in which an applicant files a claim for pharmaceutical assistance benefits.

"Coverage year" means the period of time during which a Beneficiary receives pharmaceutical assistance benefits for a claim year.
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"Covered prescription drug" means any drug included in the categories listed in Section 119.30 for which the Department on Aging approves a claim for pharmaceutical assistance benefits.

"Current income" means household income for a claim year unless an applicant requests and is allowed by the Department on Aging to use projected income for a coverage year.

"Department" means the Illinois Department of Public Aid.

"Director" means the Director of the Illinois Department of Public Aid.

"Disabled person" means a person who is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. [320 ILCS 25/3.14]

"Disease" means a chronic and possibly recurrent illness of long duration, as distinguished from an acute illness that is of short duration with recovery due to limited medical treatment (such as in the case of colds, flu, pneumonia, bronchitis, or other similar illnesses).

"Electronic application" means the electronic document set forth in subsection (a) of 86 Ill. Adm. Code 530.305.

"Household" means a claimant or a claimant and his or her spouse living together in the same residence. [320 ILCS 25/3.05]

"Household income" means the combined income of the members of a household for a claim year. [320 ILCS 25/3.06]

"Program" means the Pharmaceutical Assistance Program provided for under the Act.

"Projected income" means household income expected to be received for a coverage year.

"Verified Internet Filer" means a person who meets the eligibility qualifications under 86 Ill. Adm. Code 530.310(b) and receives a confirmation number from the
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Department on Aging acknowledging transmission of a timely filed electronic application.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)

Section 119.30  Low Income Subsidy Covered Prescription Drugs

EMERGENCY

a) To be eligible for Illinois Cares Rx, Medicare-eligible enrollees must apply for all available subsidies under Medicare Part D. The Department may deem individuals to be compliant with this requirement in cases where the Department's data clearly indicate the individual would not be eligible for any low-income subsidy.

b) Eligibility of individuals who do not apply for low-income subsidy, except in cases where Department data clearly indicate the individual would not be eligible for any low-income subsidy, may be terminated at the end of the month following the month in which written notice of termination was given to the individual.

c) If the beneficiary provides proof of application for LIS prior to the scheduled termination date, eligibility will not be terminated.

a) Drugs that fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act [225 ILCS 60], physician assistant licensed pursuant to the Physician Assistant Practice Act [225 ILCS 95], or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act [225 ILCS 65/Title 15] for treatment of heart disease and its related conditions, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Antihypertensives
2) Antianginals
3) Antiarrhythmics
4) Antihyperlipidemics
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5) Beta Blockers
6) Digitalis Glycosides
7) Hypertension/Shock
8) Diuretics
9) Potassium
10) Anticoagulants

b) Drugs purchased on or after January 1, 1987, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act, physician assistant licensed pursuant to the Physician Assistant Practice Act, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of diabetes, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Insulin
2) Insulin, Syringes and Needles
3) Oral Hypoglycemics
4) Pituitary Hormones
5) Glucose Elevators

Drugs purchased on or after January 1, 1987, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act, physician assistant licensed pursuant to the Physician Assistant Practice Act, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of arthritis, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

4) Hormones/Adrenal Cortical Steroids
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2) Analgesics/Antirheumatics
3) Analgesics/Nonopiate Agonists
4) Antiprotozoals
5) Penicillamine
6) Analgesics/Narcotic Antagonists: Gout
7) Oncolytic/Antineoplastic: Antimetabolites
8) Immunosuppressives
d) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act, physician assistant licensed pursuant to the Physician Assistant Practice Act, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of cancer, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Alkylating Agents
2) Antimetabolites
3) Antimitotic Agents
4) Epipodophyllotoxins
5) Antibiotics
6) Hormones
7) Enzymes
8) Platinum Coordination Complexes
9) Anthracenedione
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10) Substituted Ureas
11) Methylhydrazine Derivatives
12) Cytoprotective Agents
13) DNA Topoisomerase Inhibitors
14) Biological Response Modifiers
15) Retinoids
16) Monoclonal Antibodies
17) Miscellaneous Antineoplastics
18) Narcotic Agonist Analgesics
19) Narcotic Analgesic Combinations
20) Anticonvulsants

e) Cholinesterase Inhibitor drugs purchased on or after January 1, 2001, which are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act, physician assistant licensed pursuant to the Physician Assistant Practice Act, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of Alzheimer's disease, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs.

f) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act, physician assistant licensed pursuant to the Physician Assistant Practice Act, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of Parkinson's disease, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Anticholinergics
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2) Amantadine
3) Bromocriptine Mesylate
4) Carbidopa
5) Levodopa
6) Levodopa and Carbidopa
7) Pergolide Mesylate
8) Selegiline Hydrochloride
9) Entacapone
10) Tolcapone
11) Dopaminergics
12) Clonazepam

g) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act, therapeutically certified optometrist licensed pursuant to the Illinois Optometric Practice Act [225 ILCS 80/15.1], physician assistant licensed pursuant to the Physician Assistant Practice Act, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of glaucoma, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Alpha-2-Adrenergic Agonists
2) Sympathomimetics
3) Alpha-Adrenergic Blocking Agents
4) Beta-Adrenergic Blocking Agents
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5) Miotics, Direct Acting
6) Miotics, Cholinesterase Inhibitors
7) Carbonic Anhydrase Inhibitors
8) Prostaglandin Agonists
9) Miscellaneous Combinations

h) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act, physician assistant licensed pursuant to the Physician Assistant Practice Act, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of lung disease and smoking related illnesses, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Sympathomimetic Bronchodilators
2) Diluents
3) Xanthine Derivatives
4) Anticholinergic Bronchodilators
5) Leukotriene Receptor Antagonists
6) Leukotriene Formation Inhibitors
7) Corticosteroid Respiratory Inhalants
8) Mucolytics
9) Mast Cell Stabilizers
10) Respiratory Enzymes
11) Digestive Enzymes
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12) Antiasthmatic Combinations

13) Antituberculosal Agents

14) Zyban

15) Nicotine

i) Drugs purchased on or after January 1, 2001, which fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987, physician assistant licensed pursuant to the Physician Assistant Practice Act of 1987, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of osteoporosis, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Bisphosphonates
2) Selective Estrogen Receptor Modulator
3) Calcitonin-Salmon

j) Drugs purchased on or after January 1, 2004, that fall within the following categories and are prescribed by a physician licensed to practice medicine in all of its branches pursuant to the Medical Practice Act, physician assistant licensed pursuant to the Physician Assistant Practice Act, or advanced practice nurse licensed pursuant to Title 15 of the Nursing and Advanced Practice Nursing Act for the treatment of multiple sclerosis, qualify for inclusion in the Pharmaceutical Assistance Program as covered prescription drugs:

1) Corticosteroids
2) Immunomodulatory Agents (including Interferon Beta-1a and Interferon Beta-1b)
3) Immunosuppressants
4) Antineoplastics
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k) A covered prescription drug must be approved by the Food and Drug Administration of the federal Department of Health and Human Services for the treatment of a specific disease category.

l) The specific covered prescription drugs that fall within each category will be listed in a handbook to be prepared and disseminated on the internet Web site of the Department. Updates regarding changes in the categories and specific covered prescription drugs will be made as necessary.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)

Section 119.40 Automatic Enrollment of Program Beneficiaries

EMERGENCY

The Department may auto-enroll beneficiaries with a Coordinating Medicare Part D Prescription Drug Plan authorized under Section 1860D-1 of the Social Security Act. The Department shall enroll the eligible beneficiaries into a Coordinating Medicare Part D Prescription Drug Plan in order to coordinate the members' Medicare prescription drug benefit coverage with coverage under the Program.

The Department may auto-enroll beneficiaries with a Medicare discount card sponsor authorized under the federal Medicare Modernization Act of 2003 (42 USC 1395w-101 et seq.) if the member is potentially eligible for Transitional Assistance under the Medicare Modernization Act (42 USC 1395w-141). The Department shall enroll the eligible beneficiaries into the discount card program sponsored by the claims administrator for the Program in order to coordinate the members' Medicare prescription drug benefit coverage with coverage under the Program.

(Source: Amended by emergency rulemaking at 29 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)

Section 119.50 Assignment and Coordination of Benefits Fees and Co-Payments

EMERGENCY

a) Acceptance of benefits under Illinois Cares Rx, except for the Illinois Cares Rx Rebate, constitutes assignment of benefits from any private plan of assistance, including any insurance plan, public assistance program, or third party for covered prescription drugs under this Program.
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b) The Department shall charge or collect payments from any private plan of assistance, including any insurance plan, public assistance program, or third party for any claims assigned by a Beneficiary.

a) Fees

1) An applicant must pay a fee to the Department on Aging for a card as follows:

   A) An applicant must pay $5 for a card if his or her household income for a claim year is below the poverty line.

   B) An applicant must pay $25 for a card if his or her household income for a claim year is at or above the federal poverty line. (See 320 ILCS 25/4(f).)

2) The term "poverty line" means the official poverty line as defined by the Federal Office of Management and Budget at 42 USC 9902(2).

3) Fees paid for cards will not be prorated if coverage is valid for a longer or shorter period than one year as determined by the Department on Aging in converting coverage to a fiscal year basis.

b) Covered Prescription Drug Co-Payments

1) A Beneficiary must make co-payments to an authorized pharmacy for covered prescription drugs as follows:

   A) A Beneficiary who pays $5 for a card will pay no additional prescription costs until the accumulated total paid by this Program reaches $2,000 for the State fiscal year, at which point the Beneficiary must pay a co-payment equal to 20 percent of the cost of each prescription paid for by this Program for the remainder of the State fiscal year.

   B) A Beneficiary who pays $25 for a card must pay $3 for each prescription until the accumulated total paid by this Program reaches $2,000 for the State fiscal year, at which point the Beneficiary must continue to pay $3 for each prescription plus a co-payment equal to 20 percent of the cost of each prescription.
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paid for by this Program for the remainder of the State fiscal year. (See 320 ILCS 25/4(f).)

2) A Beneficiary also must pay to an authorized pharmacy an ancillary charge for any covered prescription drug that is a brand name product if the pharmacy is reimbursed at the generic price as provided in Section 119.60(d)(2).

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)

Section 119.60 Covered Services Determination of Cost of Covered Prescription Drugs

EMERGENCY

a) Illinois Cares Rx Plus

1) For an individual enrolled in a Coordinating Medicare Part D Plan, except for an individual who elects to participate in the Illinois Cares Rx Rebate Program, coverage under the Illinois Cares Rx Plus Program shall consist of:

A) Payment to the individual's Coordinating Medicare Part D PDP for premium, deductible and cost-sharing expenses except for applicable cost-sharing and co-payments set forth in Section 119.90 for pharmaceutical products covered by the individual's Medicare Part D PDP.

B) Pharmaceutical products excluded by Medicare Part D but covered by the Medical Assistance Program operated pursuant to Article V of the Public Aid Code.

2) For an individual not eligible for Medicare Part D, except for an individual who elects to participate in the Illinois Cares Rx Rebate Program, covered services under the Illinois Cares Rx Plus Program shall consist of pharmaceutical products that are covered by the Medical Assistance Program operated pursuant to Article V of the Public Aid Code.

3) For a Medicare-eligible individual who is enrolled in a non-coordinating Medicare Part D Prescription Drug Plan and not enrolled in the Illinois
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Cares Rx Rebate Program, payment of the monthly Part D premium for basic coverage directly to the individual's Medicare Part D PDP.

b) Illinois Cares Rx Basic

1) Except for an individual who elects to participate in the Illinois Cares Rx Rebate Program, for individuals enrolled in a coordinating Medicare Part D Prescription Drug Plan, coverage under the Illinois Cares Rx Basic Program shall consist of:

A) Payment to the individual's Medicare Part D PDP for premium, deductible and cost-sharing expenses except for applicable cost-sharing and co-payments described in Section 119.90 for pharmaceutical products prescribed as described in Section 119.80 that are covered by the individual's Medicare Part D PDP.

B) Payment to a pharmacy for Illinois Cares Rx Basic Covered Pharmaceutical products excluded by Medicare Part D and prescribed as set forth in Section 119.80.

2) For an individual not eligible for Medicare Part D, except for an individual who elects to participate in the Illinois Cares Rx Rebate Program, covered services under the Illinois Cares Rx Basic Program shall consist of pharmaceutical products that are prescribed as described in Section 119.80.

3) For a Medicare-eligible individual who is enrolled in a non-coordinating Medicare Part D PDP and not enrolled in the Illinois Cares Rx Rebate Program, payment of the monthly Part D premium for basic coverage directly to the individual's Medicare Part D PDP.

c) If a coordinating Medicare Part D PDP has an approved actuarially equivalent benefit design pursuant to Section 1860D-2(a)(3)(B) of the Social Security Act, the Department may adjust the threshold at which a beneficiary begins paying 20 percent cost sharing if necessary for the PDP to coordinate administration of the Illinois Cares Rx benefit with the Medicare Part D benefit. The threshold may not be lower than $1,750.

d) An individual determined eligible for Illinois Cares Rx who is enrolled in a third-party plan that provides a pharmacy benefit or a Medicare Part D PDP that is not a
Coordinating Medicare Part D PDP may choose the Illinois Cares Rx Rebate option in lieu of receiving the covered services set forth in subsection (a), (b) or (c) of this Section. An individual enrolled in Illinois Cares Rx Rebate receives his or her benefit in the form of a monetary payment (a monthly payment of $25) made to the individual. An individual who has been determined eligible for the full low income subsidy (LIS) may not choose Illinois Cares Rx Rebate.

a) The Department will pay an authorized pharmacy the reasonable cost of pharmaceutical services that such pharmacy provided to a Beneficiary pursuant to a physician's oral or written prescription authorization.

b) Determination of Reasonable Cost. For contracts executed and in effect on or after July 1, 2002, the Department will determine the rate for the reasonable cost of covered prescription drugs for which payment will be made to an authorized pharmacy in an amount equal to:

1) the lesser of:

   A) the Average Wholesale Price (AWP) for the covered prescription drug minus 14 percent, based on the National Drug Code (NDC) number for the original package size from which such drug was dispensed (AWP is determined by the most current information provided by drug pricing services such as First DataBank or other source nationally recognized in the retail prescription drug industry selected by the Department's claims processing vendor); or

   B) the Maximum Allowable Cost (MAC) for the covered prescription drug, based on the MAC list for this Program (MAC is determined by the Department's claims processing vendor); or

   C) the usual and customary cost for the covered prescription drug; plus

2) the professional dispensing fee; less

3) any applicable co-payments, deductibles, and ancillary charges.

e) Professional Dispensing Fee. For contracts executed and in effect on or after July 1, 2002, the Department shall determine the professional dispensing fee to be
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charged by authorized pharmacies. The professional dispensing fee shall be in the amount of $2.55 per prescription.

d) Payment

1) Payment to authorized pharmacies will be allowed for covered prescription drugs legally marketed in accordance with the rules and regulations of the Food and Drug Administration of the federal Department of Health and Human Services.

2) Payment will be at the generic price as provided in subsection (b) unless the following conditions exist:

A) an oral prescription is filled, refilled, or renewed for a covered prescription drug that is a brand-name product for which no generic equivalent is available; or

B) a written prescription is filled, refilled, or renewed for a covered prescription drug that is a brand-name product for which no generic equivalent is available; or

C) beginning January 1, 2001, an oral prescription is filled, refilled, or renewed for a covered prescription drug that is a brand-name product containing one or more ingredients defined as a narrow therapeutic index drug at 21 CFR 320.33 and the prescriber stipulates "brand medically necessary" and that substitution is not permitted; or

D) beginning January 1, 2001, a written prescription is filled, refilled, or renewed for a covered prescription drug that is a brand-name product containing one or more ingredients defined as a narrow therapeutic index drug at 21 CFR 320.33 and indicates on its face "brand medically necessary" and that substitution is not permitted.

e) Pharmacy's Cost of On-line Communications. Each authorized pharmacy participating in this Program shall pay all costs, charges and fees incurred by the pharmacy that are related to on-line communication and the processing of claims or other information sent to or from the Department or the Department's claims processing vendor.
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f) The reasonable cost of covered prescription drugs available to beneficiaries in this Program shall not exceed the cost of such drugs when dispensed to the general public.

g) In the event that generic equivalents for covered prescription drugs are available at lower cost, the Department shall establish the maximum allowable cost for such covered prescription drugs at the lower generic cost as provided in subsection (b).

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)

Section 119.70 Prior Authorization and Preferred Drug List (PDL) Authorized Pharmacy Qualifications

EMERGENCY

a) For Medicare-eligible individuals enrolled in a coordinating Medicare Part D PDP, the Department may enforce the PDP's Preferred Drug List by requiring tiered copays not to exceed $15 for each dispensing of a non-preferred drug.

b) For individuals not enrolled in Medicare, the Department may utilize a Preferred Drug List (PDL) enforced through the prior approval process and other utilization controls including, but not limited to, maximum quantity, daily dose and refill-too-soon.

Only pharmacies that are registered in Illinois under the Pharmacy Practice Act [225 ILCS 85] are authorized pharmacies eligible to participate in this Program. (See 320 ILCS 25/6(d).)

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)

Section 119.80 Illinois Cares Rx Basic Covered Prescription Drugs Assignment and Coordination of Benefits

EMERGENCY

The Illinois Cares Rx Basic Program shall cover pharmaceutical products as described in this Section for the treatment of heart disease and its related conditions, diabetes, arthritis, cancer, Alzheimer's disease, Parkinson's disease, glaucoma, lung disease and smoking related illnesses, osteoporosis, and multiple sclerosis.
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a) Drugs prescribed for treatment of heart disease and its related conditions that fall within the following categories qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs:

1) Antihypertensives
2) Antiarrhythmics
3) Antihyperlipidemics
4) Cardiac Glycosides
5) Calcium Channel Blockers
6) Vasodilators
7) Anti-Adrenergic/sympatholytics
8) Renin Angiotensin System Antagonists
9) Diuretics
10) Potassium Supplements
11) Anticoagulants
12) Vasopressor Used in Shock
13) Potassium Removing Agents
14) System Alkalinizers

b) Drugs that fall within the following categories for the treatment of diabetes, qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs:

1) Insulin
2) Syringes and Needles
c) Drugs that fall within the following categories and are prescribed for the treatment of arthritis, qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs:

1) Adrenocortical Steroids
2) Antimalarials
3) Analgesics
4) Antirheumatic Agents
5) Immunomodulators
6) Immunosuppressives
7) NSAIDS
8) Penicillamine

d) Drugs that fall within the following categories and are prescribed for the treatment of cancer, qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs:

1) Analgesics
2) Anticonvulsants
3) Antineoplastics
4) Immunomodulators
Drugs which fall within the following categories and are prescribed for the treatment of Alzheimer's disease, qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs:

1) NMDA Receptor Antagonists
2) Cholinesterase Inhibitors

Drugs which fall within the following categories and are prescribed for the treatment of Parkinson's disease, qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs:

1) Antiparkinson Agents, Anticholinergics
2) Antiparkinson Agents, Other
3) Pituitary Suppressive Agent

Drugs that which fall within the following categories and are prescribed for the treatment of glaucoma, qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs:

1) Miotics/Other Intracocular Pressure Reducers
2) Mydriatics
3) Carbonic Anhydrase Inhibitors

Drugs that fall within the following categories and are prescribed for the treatment of lung disease and smoking related illnesses, qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs:

1) Bronchodilators
2) Diluents
3) Mucolytics
4) Pancreatic Enzymes
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5) Smoking Cessation Products
6) Corticosteroid Respiratory Inhalants/and Combinations
7) Antituberculosis Agents
8) Mast Cell Stabilizers
9) Leukotriene Receptor Antagonists
10) Leukotriene Formation Inhibitors
11) Monoclonal Antibodies

i) Drugs that fall within the category of Bone Resorption Inhibitors and are prescribed for the treatment of osteoporosis, qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs.

j) Drugs that fall within the following categories and are prescribed for the treatment of multiple sclerosis, qualify for inclusion in the Illinois Cares Rx Basic Pharmaceutical Assistance Program as covered prescription drugs:

1) Immunomodulators
2) Immunosuppressives

k) An Illinois Cares Rx Basic covered prescription drug must be approved by the Food and Drug Administration of the federal Department of Health and Human Services for the treatment of a specific disease category.

a) Where a Beneficiary is entitled to benefits from any private plan of assistance, including any insurance plan, public assistance program, or third party for covered prescription drugs under this Program, he or she must execute an assignment of those benefits to the Department. (See 320 ILCS 25/6(d)(4).)

b) The Department shall charge or collect payments from any private plan of assistance, including any insurance plan, public assistance program, or third party for any claims assigned by a Beneficiary. (See 320 ILCS 25/4(f) and 6(d).)
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(Source: Amended by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)

**Section 119.90 Co-Payments and Cost Sharing**

Unless a federal low-income subsidy results in lesser co-payments and cost sharing, a Beneficiary enrolled in Illinois Cares Rx shall be responsible for payment of co-payments and cost sharing as follows:

a) The applicable co-payment shall be equal to that required by Medicare Part D for "other low income subsidy eligibles" pursuant to 42 CFR 423.782(b), (in 2006, those co-payments are $2 for each dispensing of a generic prescription and $5 for each dispensing of a brand name prescription). For individuals enrolled in Medicare Part D, copayments are $15 for each dispensing of a non-preferred drug.

b) Twenty percent of the reimbursable amount of the prescription plus the applicable co-payment for each prescription dispensed after the Illinois Cares Rx benefit amount has reached $1,750 for the calendar year.

c) For those enrolled in Medicare Part D, the Illinois Cares Rx benefit amount is the total payments made by the PDP to pharmacies on behalf of the beneficiary whether paid as a part of the Medicare benefit or the Illinois Cares Rx benefit. For those not in Medicare, the Illinois Cares Rx benefit amount is the total payments made by the Department to pharmacies on behalf of the beneficiary.

d) A Beneficiary also must pay to an authorized pharmacy an ancillary charge for any covered prescription drug that is a brand name product if the pharmacy is reimbursed at the generic price as provided in Section 119.100(b)(2) and (3).

*Payments to authorized pharmacies under the Act shall be made in accordance with the State Prompt Payment Act [30 ILCS 540]. [320 ILCS 25/6(d)(7)]*

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)
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a) Direct payment to pharmacies by the Department is made only for pharmaceutical products for individuals not enrolled in Medicare Part D or for Medicare Part D excluded pharmaceutical products covered by the Department when dispensed to individuals enrolled in Medicare Part D.

b) Reimbursable Amount

1) Except as provided in subsections (b)(2), (3) and (4) of this Section, the reimbursable amount for a pharmaceutical product eligible for direct payment by the Department shall be:

A) For legend (prescription) drugs, the Department shall pay the lower of:
   i) the pharmacy's prevailing charge to the general public; or
   ii) the Department's maximum price plus a dispensing fee of $2.25 for both generic and brand name drugs less applicable co-payments and cost sharing as set forth in Section 119.90.

B) For generic drugs, the Department's maximum price is calculated as the lowest of:
   i) the average wholesale price minus 25 percent; or
   ii) the Federal Upper Limit for drugs; or
   iii) the State Upper Limit for drugs.

C) For brand name drugs, the Department's maximum price is calculated as the average wholesale price minus 14 percent.

D) For those over-the-counter drugs that are covered, the Department shall pay the lower of:
   i) the prevailing charge to the general public; or
   ii) the average wholesale price plus 25 percent.
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2) If a generic drug is available, based upon the Illinois Formulary for Drug Product Selection Program (77 Ill. Adm. Code 790), and the individual wants the brand name equivalent of the drug, the reimbursable amount shall be that of the generic drug.

3) If a brand name drug is dispensed when the reimbursable amount is that for the generic drug, the individual shall be responsible for paying the difference between the reimbursable amount (based upon the generic drug) and what would have been the reimbursable amount for the brand name drug, plus the applicable co-payment or cost-sharing.

4) If the Department contracts with a third-party to manage some portion of the Illinois Cares Rx Program, the reimbursable amount shall be the price established by the third party contractor for its pharmacy network or the amount required to be paid to pharmacies by the Department's contract with the third party.

5) Payment by the Department to a participating pharmacy for a pharmaceutical product dispensed to an individual eligible for Illinois Cares Rx shall be the difference of the reimbursable amount, as described in subsection (b) of this Section, less applicable co-payments, as described in Section 119.90, and any amount paid or payable by Medicare or another third-party as described at 89 Ill. Adm. Code 140.12(h)(2).

6) The reimbursable amount to pharmacies for prescriptions processed by a Medicare Part D PDP shall be at the contracted rate between the pharmacy and the PDP.

e) Provider Participation

In order to bill the Department directly for prescriptions dispensed to participants in the Illinois Cares Rx Program, pharmacies shall be enrolled in the Medical Assistance Program under Article V of the Public Aid Code.

a) The Director or his or her designee has the authority to enter into written contracts with any State agency, instrumentality, or political subdivision, or a fiscal intermediary for the purpose of making payments to authorized pharmacies who participate in this Program and coordinating this program with other public assistance programs. [320 ILCS 25/6(d)]
b) Contracts entered into by or on behalf of the Department and authorized pharmacies shall stipulate the terms and conditions for participation in this Program and the right of the Department to terminate participation for breach of contract or violation of federal or State law. [320 ILCS 25/6(d)(1)]

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)

Section 119.110 Inspection and Disclosure of Records Limitation on Prescription Size

EMERGENCY

a) In order to ensure compliance with the requirements of the Act and to prevent fraud, the Department, or its designee, shall have the right:

1) to inspect the books and records of all authorized pharmacies (see 320 ILCS 25/6(d)(5)); and

2) to require disclosure of information on individuals who receive health coverage, pharmaceutical benefits, or related services as policyholders, subscribers, or plan participants from entities subject to the Illinois Insurance Code [215 ILCS 5], Comprehensive Health Insurance Plan Act [215 ILCS 105], Dental Service Plan Act [225 ILCS 25], Children's Health Insurance Program Act [215 ILCS 106], Health Care Purchasing Group Act [215 ILCS 123], Health Maintenance Organization Act [215 ILCS 125] Limited Health Service Organization Act [215 ILCS 130], Voluntary Health Services Plans Act [215 ILCS 165], and Worker's Compensation Act [820 ILCS 305].

b) Information received by the Department or its designee shall be confidential except for official purposes and as otherwise provided in the Act. (See 320 ILCS 25/4.1.)

An authorized pharmacy may not provide a Beneficiary with more than a 34 day supply of any covered prescription drug in filling, refilling, or renewing a prescription, except as otherwise specified for medical or utilization control reasons in the handbook and this Part prepared and disseminated on the internet Web site of the Department. [320 ILCS 25/6(d)(2)] Such an exception is specified in the handbook for covered prescription drugs classified as maintenance drugs that are less expensive to dispense in greater quantities due to larger daily dose requirements.
Section 119.120 Establishment of Liens

Inspection and Disclosure of Records

EMERGENCY

The Director is entitled to establish a lien on any and all causes of action which accrue to a Beneficiary as a result of injuries for which covered prescription drugs are directly or indirectly prescribed and for which payment was made under this program.

a) In order to ensure compliance with the requirements of the Act and to prevent fraud, the Department, or its designee, shall have the right:

1) to inspect the books and records of all authorized pharmacies [320 ILCS 25/6(d)(5)]; and

2) to require disclosure of information on individuals who receive health coverage, pharmaceutical benefits, or related services as policyholders, subscribers, or plan participants from entities subject to the Illinois Insurance Code [215 ILCS 5], Comprehensive Health Insurance Plan Act [215 ILCS 105], Dental Service Plan Act [225 ILCS 25], Children’s Health Insurance Program Act [215 ILCS 106], Health Care Purchasing Group Act [215 ILCS 123], Health Maintenance Organization Act [215 ILCS 125], Limited Health Service Organization Act [215 ILCS 130], Voluntary Health Services Plans Act [215 ILCS 165], and Worker’s Compensation Act [820 ILCS 305].

b) Information received by the Department or its designee shall be confidential except for official purposes and as otherwise provided in the Act. [320 ILCS 25/4.1]

Section 119.130 Penalties

Establishment of Liens

EMERGENCY

a) Any person who takes either of the following actions is guilty of a Class 4 felony for the first offense and a Class 3 felony for each subsequent offense:
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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1) on behalf of an authorized pharmacy, files a fraudulent claim for payment; or

2) fraudulently uses a card to obtain covered prescription drugs. (See 320 ILCS 25/9.)

b) The Department, in cooperation with the Department on Aging, will recover from any beneficiary or authorized pharmacy any amount paid under this program on account of an erroneous or fraudulent claim, together with 6 percent interest per year.

c) A prosecution for violation of the provisions of the Act may be undertaken at any time within three years after the commission of that violation. [320 ILCS 25/9]

The Director is entitled to establish a lien on any and all causes of action which accrue to a Beneficiary as a result of injuries for which covered prescription drugs are directly or indirectly prescribed and for which payment was made under this program. [320 ILCS 25/6(d)(3)]

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)

Section 119.140 Penalties (Repealed)

EMERGENCY

a) Any person who takes either of the following actions is guilty of a Class 4 felony for the first offense and a Class 3 felony for each subsequent offense:

1) on behalf of an authorized pharmacy, files a fraudulent claim for payment; or

2) fraudulently uses a card to obtain covered prescription drugs. [320 ILCS 25/9]

b) The Department, in cooperation with the Department on Aging, will recover from any beneficiary or authorized pharmacy any amount paid under this program on account of an erroneous or fraudulent claim, together with 6 percent interest per year.
e) A prosecution for violation of the provisions of the Act may be undertaken at any time within three years after the commission of that violation. [320 ILCS 25/9]

(Source: Repealed by emergency rulemaking at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days)
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1) Heading of the Part: Medical Assistance Programs

2) Code Citation: 89 Ill. Adm. Code 120

3) Section Number: Emergency Action:
   120.520    Repealed


5) Effective Date of Amendment: January 1, 2006

6) If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: Not applicable

7) Date Filed with the Index Department: December 30, 2005

8) A copy of the emergency amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Reason for Emergency: This emergency repeal of the SeniorCare provisions in Section 120.520 is necessary because SeniorCare has been replaced by the Illinois Cares Rx Program under Public Act 94-86. Section 5-45 of Public Act 94-48 specifically authorizes emergency rulemaking for the implementation of these changes for fiscal year 2006.

10) A Complete Description of the Subjects and Issues Involved: The SeniorCare provisions at Section 120.520 are being repealed because SeniorCare has been replaced by the Illinois Cares Rx Program under Public Act 94-86.

11) Are there any other amendments pending on this Part? No

12) Statement of Statewide Policy Objectives: This emergency amendment neither creates nor expands any State mandate affecting units of local government.

13) Information and questions regarding this amendment shall be directed to:

   Joanne Scattoloni
   Office of the General Counsel, Rules Section
   Illinois Department of Healthcare and Family Services
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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201 South Grand Ave East, Third Floor
Springfield, Illinois 62763-0002

217/524-0081

The full text of the Emergency Amendment begins on the next page:
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CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 120
MEDICAL ASSISTANCE PROGRAMS

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SUBPART B: ASSISTANCE STANDARDS

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120.20 MANG(AABD) Income Standard
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120.64 MANG(P) Cases
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SUBPART F: MIGRANT MEDICAL PROGRAM

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120.90  Migrant Medical Program (Repealed)
120.91  Income Standards (Repealed)

SUBPART G: AID TO THE MEDICALLY INDIGENT

Section
120.200  Elimination Of Aid To The Medically Indigent
120.208  Client Cooperation (Repealed)
120.210  Citizenship (Repealed)
120.211  Residence (Repealed)
120.212  Age (Repealed)
120.215  Relationship (Repealed)
120.216  Living Arrangement (Repealed)
120.217  Supplemental Payments (Repealed)
120.218  Institutional Status (Repealed)
120.224  Foster Care Program (Repealed)
120.225  Social Security Numbers (Repealed)
120.230  Unearned Income (Repealed)
120.235  Exempt Unearned Income (Repealed)
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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)
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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)
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SUBPART I: SPECIAL PROGRAMS

Section 120.520 SeniorCare (Repealed)

To be eligible for SeniorCare pharmaceutical benefits as set forth at 89 Ill. Adm. Code 140.405, an individual must meet all of the following eligibility requirements:

1) Be a U.S. citizen or qualify as an eligible non-citizen pursuant to Section 120.310.

2) Reside in Illinois.

3) Be 65 years of age or older.

4) Assign rights to medical support and collection of payments as described in Section 120.319.

5) Furnish his or her Social Security Number.

6) Have countable annual income at or below 200 percent of the poverty guidelines published annually by the U.S. Department of Health and Human Services.

The earned and unearned income of the applicant and his or her spouse (if the spouse resides with the applicant) shall be counted when determining eligibility, except that the following shall not be counted:

1) Cash gifts.
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2) child support payments;
3) Circuit Breaker grants;
4) damages awarded from a lawsuit for a physical personal injury or sickness;
5) Energy Assistance payments;
6) federal income tax refunds;
7) IRAs "rolled over" into other retirement accounts;
8) lump sums from inheritances;
9) lump sums from insurance policies;
10) money borrowed against a life insurance policy;
11) reverse mortgage income;
12) stipends from the Foster Parent and Foster Grandparent programs; and
13) Worker's Compensation.

e) Assets shall not be considered.

d) SeniorCare participants shall be exempt from the requirements of 89 Ill. Adm. Code 102.210, Estate Claims, with regard to expenditures made for SeniorCare benefits.

e) An individual who is eligible for medical assistance with a spenddown may participate in SeniorCare.

f) An individual who receives benefits from any of the Medicare Savings programs (QMB, SLIB, or QI) may participate in SeniorCare.

g) Application Process

1) Individuals shall apply by completing and submitting an application as
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specified by the Illinois Department of Revenue.

2) Spouses may apply on the same application as long as the application contains both signatures.

3) After eligibility is determined by the Illinois Department of Revenue, notice of the outcome shall be sent to the applicant.

4) An individual enrolled in SeniorCare shall receive coverage under his or her own name and unique Recipient Identification Number.

h) Enrollment Periods

1) Enrollment shall be effective no later than one month after the date when the applicant was determined to be eligible for the program.

2) An individual who first enrolls in SeniorCare between July 1 and December 31 of any year shall be enrolled through the end of that State fiscal year. For example, an individual who first enrolls on December 1, 2002, shall be eligible through June 30, 2003.

3) An individual who first enrolls in SeniorCare between January 1 and June 30 of any year shall be enrolled through the end of that fiscal year plus all of the following fiscal year. For example, an individual who first enrolls on January 1, 2003, shall be eligible through June 30, 2004.

4) Individuals must reapply annually.

5) Subsequent uninterrupted periods of enrollment shall be for 12 months and shall be coincident with the State fiscal year.

i) Authorization of SeniorCare

1) Once an individual has been determined eligible for SeniorCare, a SeniorCare identification card shall be sent to the individual.

2) Upon receipt of the card, the participant shall have the option of receiving a SeniorCare Rebate as established in 89 Ill. Adm. Code 140.405 instead of using the SeniorCare card. Enrollment in the SeniorCare Rebate option shall be effective prospectively for the month following the month in
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which the individual is approved for SeniorCare Rebate.

j) SeniorCare coverage shall terminate:

1) at the end of a participant's enrollment period unless the participant reenrolls timely and is found to continue to be eligible;

2) when a participant no longer resides in Illinois;

3) when a participant becomes an inmate of a public institution as set forth in 42 C.F.R. 435.1008;

4) upon a participant's death; or

5) upon discovery that the initial determination of the participant's eligibility was incorrect.

k) Individuals applying for or enrolled in SeniorCare shall be entitled to appeal rights as described at 89 Ill. Adm. Code 102.80.

(Source: Repealed by emergency rulemaking at 30 Ill. Reg. 521, effective January 1, 2006, for a maximum of 150 days)
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1) **Heading of the Part:** Children's Health Insurance Program

2) **Code Citation:** 89 Ill. Adm. Code 125

3) **Section Numbers:**

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4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 94-48

5) **Effective Date:** January 1, 2006

6) **If this emergency amendment 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:** December 29, 2005

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.**
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9) **Reason for Emergency:** These emergency amendments concerning FamilyCare are being filed pursuant to the enactment of the State's budget implementation plan for fiscal year 2006. The amendments address an expansion of health care under which more adults will qualify for medical benefits. This FamilyCare expansion will provide medical coverage to parents and caretaker relatives who are 19 years of age or older, who have incomes above 133 percent and up to and including 185 percent of the Federal Poverty Level, and who are caretaker relatives, including parents, raising children younger than 19 years of age. Section 5-45 of Public Act 94-48 specifically authorizes emergency rulemaking for the implementation of these changes for fiscal year 2006.

10) **Complete Description of the Subjects and Issues Involved:** This emergency rulemaking addresses an expansion of health care under which more adults will qualify for medical benefits. This expansion of medical benefits for adults, known as FamilyCare, will provide medical coverage to caretaker relatives, including parents, who are 19 years of age or older, who have incomes above 133 percent and up to and including 185 percent of the Federal Poverty Level, and who are responsible for raising children who are eligible for HFS medical benefits. These changes mark the first time medical coverage for adults is available under the health plans established pursuant to the Children's Health Insurance Program Act (CHIPA). Eligible adults will receive the same medical benefits and have the same cost sharing requirements depending upon income as children under FamilyCare Share, FamilyCare Premium and FamilyCare Rebate, as described in the emergency rulemaking. Previous expansions of FamilyCare were governed by the Public Aid Code and rules promulgated at 89 Ill. Adm. Code 120 because they affected individuals with income no greater than 133 percent of the Federal Poverty Level.

Federal funding of this expansion of care to eligible adults is permitted under the federally approved KidCare Parent Coverage Waiver. The proposed changes are expected to make medical coverage available to an additional 74,000 parents and caretaker relatives.

This health care expansion under the Children's Health Insurance Program is a component of the fiscal year 2006 budget implementation plan. Expenditures for the expansion are eligible for federal matching funds. The estimated fiscal year 2006 cost increase resulting from these changes, beginning January 1, 2006, is anticipated at approximately $16.3 million gross with a State share of $5.7 million. The estimated cost increase on an annual basis will be approximately $63 million with a State share of $22 million.

11) **Are there any other amendments pending on this Part?** Yes

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125.100 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.110 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.200 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.205 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.220 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.230 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.240 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.245 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.260 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.265 New Section December 2, 2005 (29 Ill. Reg. 19474)
125.300 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.305 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.310 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.320 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.330 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.340 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.400 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.420 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.430 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.440 Amendment December 2, 2005 (29 Ill. Reg. 19474)
125.445 Amendment December 2, 2005 (29 Ill. Reg. 19474)

12) Statement of Statewide Policy Objective: These emergency amendments neither create nor expand any State mandate affecting units of local government.

13) Information and questions regarding these adopted amendments shall be directed to:

Joanne Scattoloni
Office of the General Counsel, Rules Section
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, Third Floor
Springfield, Illinois 62763-0002

(217) 524-0081

The full text of the Emergency Amendments begins on the next page:
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SUBPART D: KIDCARE/FAMILYCARE REBATE

Section
125.400  | Minimum Coverage Requirements
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| 125.445  | Rebate Overpayments

AUTHORITY: Implementing and authorized by the Children's Health Insurance Program Act [215 ILCS 106] and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13].

Section 125.100  General Description

This Part implements the Children's Health Insurance Program Act [215 ILCS 106] that authorizes the Department to administer an insurance program to assist families in purchasing health insurance benefits for their children. The Program is not an entitlement. The Program will enable eligible residents of Illinois, to the extent funding permits, access to health benefits coverage. The Department shall provide health benefits coverage to eligible individuals through purchasing or providing health care benefits or by subsidizing the cost of privately sponsored health insurance, including employer-based health insurance.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.110  Definitions

For the purpose of this Part, the following terms shall be defined as follows:

"Act" means the Children's Health Insurance Program Act [215 ILCS 106].

"Caretaker Relative" means a relative as specified below, with whom the child lives, who is providing care, supervision and a home for the child. Caretaker Relatives include:

Blood or adoptive relatives within the fifth degree of kinship:

father and mother
brother and sister
grandmother and grandfather (including up to great-great-great)
uncle and aunt (including up to great-great)
nephew and niece (including up to great-great)
first cousin
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first cousin once removed (child of first cousin)

second cousin (child of great-aunt/uncle)

Step relatives:

step-father and step-mother

step-brother and step-sister

A person who is or has been married to one of the above relatives.

"Department" means the Department of Healthcare and Family Services and any successor agencies.

"Eligible Adult" means an individual 19 years or older who is a parent or other Caretaker Relative and that individual's spouse if they reside together.

"Family" means the child applying for the Program and the following individuals who live with the child:

The child's parents

The spouse of the child's parent

Children under 19 years of age of the parents or the parent's spouse

The spouse of the child

The children of the child

If any of the above is pregnant, the unborn children.

"FamilyCare" means expansion of coverage to include Eligible Adults as permitted by KidCare Parent Coverage Waiver.

"Federal Poverty Level" means the federal poverty income guidelines as established by the federal Department of Health and Human Services and published in the Federal Register.
"KidCare/FamilyCare Health Plan" means the health benefits coverage containing cost sharing features that is available to eligible Families under the Children's Health Insurance Program or the KidCare Parent Coverage Waiver, and includes KidCare/FamilyCare Share (no premium required) and KidCare/FamilyCare Premium (premium required).

"KidCare/FamilyCare Rebate" means the program under which the Department, on behalf of an eligible individual, makes Rebate payments to offset a Family's cost of insuring an individual under privately sponsored or employer-based health insurance.

"Medical Assistance" means health care benefits provided under Article V of the Illinois Public Aid Code.

"Program" means the program created under the Children's Health Insurance Program Act and this Part.

"Rebate" means the payment made by the Department under KidCare Rebate.

"REV" means the Recipient Eligibility Verification system through which medical providers can obtain eligibility and claim status information electronically.

"Significant Health Insurance" means coverage that includes physician services and inpatient hospital services that would qualify for coverage under KidCare Rebate.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section 125.200 Eligibility for Children's Health Insurance Program

A child or Eligible Adult may be eligible under the Program provided that all of the following eligibility criteria are met:

a) The child or Eligible Adult is not eligible for Medical Assistance including Section 120.32.
b) The child is under 19 years of age.

c) Countable Income

1) The child is a member of a Family whose monthly countable income is above 133 percent of the Federal Poverty Level and at or below 200 percent of the Federal Poverty Level.

2) An Eligible Adult is a member of a Family whose monthly income is above 133 percent of the Federal Poverty Level and at or below 185 percent of the Federal Poverty Level.

d) The individual is a resident of the State of Illinois.

e) The individual is either a United States citizen or included in one of the following categories of non-citizens:

1) A United States veteran honorably discharged or an individual on active military duty, or the spouse and unmarried dependent children of such a person. Unmarried dependent children of either a United States veteran honorably discharged or a person on active military duty.

2) Refugees under Section 207 of the Immigration and Nationality Act.

3) Asylees under Section 208 of the Immigration and Nationality Act.

4) Individuals for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act.

5) Individuals granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980.

6) Individuals lawfully admitted for permanent residence under the Immigration and Nationality Act.

7) Parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act.

8) Nationals of Cuba or Haiti.
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9) Individuals identified by the Federal Office of Refugee Resettlement (ORR) as victims of trafficking.

10) Amerasians from Vietnam.

11) Members of the Hmong or Highland Laotian tribe when the tribe helped United States personnel by taking part in military or rescue operations.

12) American Indians born in Canada.

13) Individuals who are a spouse, widow or child of a United States citizen or a spouse or a child or a legal permanent resident (LPR) who have been battered or subjected to extreme cruelty by the United States citizen or LPR or a member of that relative's family who lived with them, who no longer live with the abuser or plan to live separately within one month of assistance and whose need for assistance is due, at least in part, to the abuse.

f) The Individual's child's Social Security Number (SSN) is provided to the Department, or if it has not been issued or is not known, proof that application has been made for an SSN is provided.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.205 Eligibility Exclusions and Terminations

EMERGENCY

a) An individual child shall not be determined eligible for coverage under the Program if:

1) The individual child is an inmate of a public institution.

2) The individual child is a patient in an institution for mental diseases.

3) The individual child is a member of a Family that is eligible for health benefits coverage under a State of Illinois health benefits plan on the basis of a member's employment with a public agency.

4) The individual child is in categories described in Section 125.200(e)(6) or (e)(7), and the individual child entered the United States on or after August
b) An individual’s child with significant health insurance can choose between KidCare/FamilyCare Health Plan and KidCare/FamilyCare Rebate.

c) Termination of an individual's child's coverage under the Program shall be initiated upon the occurrence of any of the following events:

1) The child becomes ineligible due to:

A) Losing his or her Illinois residency.
B) Attaining 19 years of age.
C) Becoming enrolled in Medical Assistance.
D) Meeting the provisions of subsection (a)(1) or (a)(3) of this Section.

2) An Eligible Adult becomes ineligible due to:

A) Losing his or her Illinois residency.
B) No child under 19 years of age remaining in the family.
C) Becoming enrolled in Medical Assistance.
D) Meeting the provisions of subsection (a)(1) or (a)(3) of this Section.
E) Income exceeding the levels established in Section 125.200(b)(2).

3) A child or an Eligible Adult becomes ineligible due to:

A) The child's Caretaker Relative fails to pay the required premiums under the KidCare/FamilyCare Health Plan, as specified in Sections 125.320 and 125.330, are not paid.

B) An individual’s child enrolled in KidCare Rebate no longer being covered under a private or employer-based health insurance plan,
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except that an individual's child may change enrollment from KidCare/FamilyCare Rebate to the KidCare/FamilyCare Health Plan pursuant to Section 125.260(c).

C) 4) The individual's Caretaker Relative fails to report to the Department changes in non-financial information that impacts upon the individual's child's eligibility for the Program.

D) 5) The individual's Caretaker Relative makes a request to the Department to terminate the coverage.

E) 6) The Department determines that the individual is no longer eligible based on any other applicable State or federal law or regulation.

F) 7) The Department determines that the individual's Caretaker Relative failed to provide eligibility information that was truthful and accurate to the best of the applicant's knowledge and belief and that affected the eligibility determination.

G) 8) There has been a Rebate overpayment and it has not been repaid to the Department according to terms established by the Department, which may include recoupment out of future Rebate payments or a payment plan.

H) 9) The Department determines that the individual's child's eligibility was incorrectly determined.

I) 10) The application was approved pending receipt of the individual's Social Security Number and it is not provided later when requested.

d) Following termination of an individual's child's coverage under the Program, the following action is required before the individual can be re-enrolled:

1) A new application must be completed and the individual must be determined otherwise eligible;

2) There must be full payment of premiums under the KidCare Health Plan, for periods in which a premium was owed and not paid for the individual, including premiums owed when the individual was,
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For purposes of this Part, a member of another Family;

3) Any overpayment of Rebates paid on behalf of the individual child must be repaid to the Department. A Rebate overpayment shall be considered repaid if the Department can recoup the overpayment out of future Rebate payments;

4) If the termination was the result of non-payment of premiums, the individual child must be out of the Program for three months before re-enrollment; and

5) The first month's premium must be paid if the individual child is eligible for KidCare/FamilyCare Premium and the individual's Family chose to have coverage under subsection (g) of this Section when the individual child was initially enrolled in the Program or if there was an unpaid premium on the date the individual's previous case was canceled.

e) An application will be denied if any of the Eligible Adults in the Family was responsible as a Caretaker Relative or Eligible Adult of a child during a period for which a premium under the Program was due to the Department for that child and the premium remains unpaid at the time of application. Such an application shall be denied regardless of whether the individual child for whom the premium remains unpaid is included in the application.

f) An application will be denied if any of the Eligible Adults in the Family was a Caretaker Relative of a child during a period for which a Rebate overpayment was received or was the payee of a Rebate overpayment and the overpayment has not been repaid to the Department. Such an application shall be denied regardless of whether the individual child for whom the Rebate overpayment remains unpaid is included in the application.

g) A certificate of prior creditable coverage will be issued when individual's child's coverage is terminated under the KidCare/FamilyCare Health Plan.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.220 Application Process
EMERGENCY
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a) Families will be able to apply for the Program using any of the following methods:

1) Submit the Department's application to an address specified by the Department.
2) Apply at a Department of Human Services (DHS) local office.
3) Apply through a KidCare Application Agent that has an agreement in place with the Department.
4) Apply online at www.kidcareillinois.com.
5) Additional methods that the Department establishes.

b) The application will meet all requirements found at 89 Ill. Adm. Code 110.10.

c) Families are obligated to provide truthful and accurate information for determining eligibility and to report promptly to the Department any change in non-financial information provided on the application or financial information for Eligible Adults.

d) The Department may cease accepting or processing applications if enrollment in the Program is closed due to limited appropriations.

e) The Department shall send a notification of its determination within 45 calendar days after the date the application was received.

f) The 45 calendar days may be extended when a decision cannot be reached because:

1) information necessary for a determination is available only from a third party and the party fails to respond or delays his or her response to the request for such information, or
2) additional information is needed from the applicant.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)
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Section 125.230 Determination of Monthly Countable Income

EMERGENCY

a) Monthly countable income for applications processed for the Program is determined by taking the total gross monthly income of the Family and subtracting allowable deductions and exemptions as described in 89 Ill. Adm. Code 120, Subpart H.

b) For the purpose of subsection (a) of this Section, the number of individuals in the Family determines the applicable income standard.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.240 Eligibility Determination and Enrollment Process

EMERGENCY

a) If the monthly countable income is at or below 133 percent of the Federal Poverty Level for the number of individuals in the Family, the child will be enrolled in Medical Assistance, if otherwise determined eligible pursuant to 89 Ill. Adm. Code 120, Subpart H.

b) If the monthly countable income is above 133 percent and at or below 200 percent of the Federal Poverty Level for a child or at or below 185 percent of poverty for an adult for the number of individuals in the Family, and all other eligibility requirements of this Part are met and enrollment is open, the child will be enrolled in the Program.

c) For purposes of cost sharing, Families in the KidCare/FamilyCare Health Plan will be enrolled into either KidCare/FamilyCare Share or KidCare/FamilyCare Premium as follows:

1) If monthly countable income is above 133 percent and at or below 150 percent of the Federal Poverty Level for the number of individuals in the Family, the child will be enrolled in KidCare/FamilyCare Share.

2) If monthly countable income is above 150 percent and at or below 200 percent of the Federal Poverty Level for the number of individuals in the Family, the child will be enrolled in KidCare Premium or if monthly countable income is above 150 percent and at or below 185...
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percent of the Federal Poverty Level for the number of individuals in the Family, an Eligible Adult will be enrolled in the FamilyCare Premium.

d) Applicants will be notified, in writing, regarding the outcome of their eligibility determination.

e) Eligibility determinations for the Program made by the fifteenth day of the month will be effective the first day of the following month. Eligibility determinations for the Program made after the fifteenth day of the month will be effective no later than the first day of the second month following that determination.

1) The duration of eligibility for the Program for children will be 12 months unless one of the events described in Section 125.205(c)(1) or (c)(3) occurs. The 12 months of eligibility will commence when the first child in a Family is covered under the Program. Children added to the Program after the eligibility period begins will be eligible for the balance of the 12-month eligibility period.

2) The duration of eligibility for the Program for Eligible Adults will be 12 months unless one of the events described in subsection (c)(2) or (c)(3) occurs. The 12 months of eligibility will commence when the first individual in a Family is covered under the Program.

f) Individuals determined to be eligible for the KidCare/FamilyCare Health Plan may obtain coverage for a period prior to the date of application for the Program. This coverage shall be subject to the following:

1) The Family must request the prior coverage for the child within six months following the initial date of coverage under the KidCare/FamilyCare Health Plan.

2) The prior coverage will be individual child specific and will only be available the first time the individual child is enrolled in the Program.

3) The prior coverage will begin with services rendered during the two weeks prior to the date the individual's application for the KidCare/FamilyCare Health Plan was filed and will continue until the individual's coverage under the KidCare/FamilyCare Health Plan is effective pursuant to subsection Section 125.240(e).
Section 125.245 Appeals

a) Any person who applies for or receives assistance under the Program shall have the right to appeal any of the following actions:

1) Refusal to accept an application.

2) Denial of an application or cancellation at the annual renewal including denial based on failure to meet one or more of the eligibility requirements specified in this Part. If the denial or cancellation is not upheld on appeal, coverage under the Program shall be retroactive to the date the coverage would have commenced had the application or annual determination been approved. However, if the child is eligible for KidCare/FamilyCare Premium, it will be at the Family’s option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date the coverage would have commenced had the application been approved. All premium and copayment requirements shall apply to any retroactive period.

3) Termination of coverage based on failure to continue to meet one or more of the eligibility requirements specified in this Part. If the termination is not upheld on appeal and benefits were not continued during the appeal, coverage under the Program shall be reinstated retroactive to the termination date. However, if the child is eligible for KidCare Premium, it will be at the Family’s option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date of termination. All premium and copayment requirements shall apply to any retroactive period.

4) Determination of the amount of the premium, Rebate, or copayments required. Coverage, Rebate amount and any premium or copayment requirements, as determined by the Department, shall remain in force during the appeal process.

b) In addition to the actions that are appealable under subsection (a) of this Section,
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individuals covered under the KidCare/FamilyCare Health Plan shall have the right to appeal any of the following actions:

1) Termination of coverage due to non-payment of the required premium.

2) Denial of payment for a medical service or item that requires prior approval.

3) Decision granting prior approval for a lesser or different medical service or item than was originally requested.

c) The Department's decision to deny an application due to closing of enrollment for the Program shall not be appealable.

d) Individuals may initiate the appeal process by:

1) Filing a written, signed request for a hearing directed to the Department's Assistance Hearings Section;

2) Calling a toll free telephone number, (800/435-0774), or as designated by the Department.

e) The request for a hearing may be filed by the individual affected by the action or by the individual's authorized representative.

f) For purposes of initiating the appeal process, a copy of a written, signed request for a hearing is considered the same as the original written, signed request.

g) The request for a hearing must be filed no later than 60 days after notice of the appealable action has been given.

h) If an appeal is initiated within ten calendar days after the notice of intended Department action and the individual specifically requests that the benefits be continued, benefits shall be continued at the level in effect prior to the proposed action, pending the results of the fair hearing process. All copayment obligations including premiums must be met during the period.

i) The provisions of Subpart A of the Department's administrative rules at 89 Ill. Adm. Code 104, Practice in Administrative Hearings, shall govern the handling of appeals and the conduct of hearings under the Program.
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j) An individual can, prior to a decision being rendered on the appeal, reapply for the Program.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.260 Adding Children to and Removing Children from the Program and Changes in Participation

a) Families may add eligible children to the Program during the 12-month eligibility period, without eligibility being reviewed by the Department. Coverage for children added shall be prospective from the effective date determined according to Section 125.240(e) and shall continue for the remainder of the Family's original 12-month eligibility period and may also include any prior coverage established pursuant to Section 125.240(f)(g).

b) Premium amounts under the KidCare/FamilyCare Health Plan and Rebates under KidCare/FamilyCare Rebate will be adjusted to reflect adding or removing a child from the Program.

c) A child who would otherwise be terminated from KidCare/FamilyCare Rebate because of losing private or employer-sponsored health insurance pursuant to 125.205(b)(3) may change coverage to the KidCare/FamilyCare Health Plan without eligibility being reviewed by the Department if there is no unpaid Rebate overpayment. Coverage under the KidCare/FamilyCare Health Plan shall be prospective from the effective date determined according to Section 125.240(e) and shall continue for the remainder of the existing 12-month eligibility period. However, at the time of the change in coverage a Family may choose to have the KidCare/FamilyCare Share or Premium coverage retroactive to the first day of the first month following the last month of coverage under the private or employer sponsored insurance if the Family refunds within 30 days after the Department's notice that the child's coverage has been changed to KidCare/FamilyCare Health Plan and any Rebate payment received for a month in which there was no private or employer based insurance coverage, notwithstanding Section 125.445(c).

d) A child with significant health insurance may choose to change who would otherwise be terminated from the KidCare Health Plan pursuant to Section 125.205(c)(6) may change coverage to KidCare/FamilyCare Rebate without eligibility being reviewed by the Department if the Family child obtains coverage through a private or employer-based insurance plan, returns a Rebate form within...
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30 days after the Department's notice that the Family's coverage under KidCare Health Plan is being terminated and there are no unpaid premiums owed to the Department. Coverage under KidCare/FamilyCare Rebate shall be prospective from the effective date determined according to Section 125.240(e) following receipt by the Department of a completed Rebate Form and shall continue for the remainder of the existing 12-month eligibility period.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.265 Adding Eligible Adults to the Program and Changes in Participation

EMERGENCY

a) Families may add Eligible Adults to the Program during the 12-month eligibility period if the Family income meets the income levels as stated in Section 125.240. Coverage for the added Eligible Adult shall be prospective from the effective date determined according to Section 125.240(e) and may also include any prior coverage established pursuant to Section 125.240(f).

b) Premium amounts under the KidCare/FamilyCare Health Plan and Rebates under KidCare/FamilyCare Rebate will be adjusted to reflect adding or removing an Eligible Adult from the Program.

c) An Eligible Adult who would otherwise be terminated from KidCare/FamilyCare Rebate because of losing private or employer-sponsored health insurance may change coverage to the KidCare/FamilyCare Health Plan if there is no unpaid Rebate overpayment. Coverage under the KidCare/FamilyCare Health Plan shall be prospective from the effective date determined according to Section 125.240(e). However, at the time of the change in coverage a Family may choose to have the KidCare/FamilyCare Share or Premium coverage retroactive to the first day of the first month following the last month of coverage under the private or employer sponsored insurance if the Family refunds, within 30 days after the Department's notice that the person's coverage has been changed to KidCare/FamilyCare Health Plan, any Rebate payment received for a month in which there was no private or employer based insurance coverage, notwithstanding Section 125.445(c).

d) An Eligible Adult with significant health insurance may change coverage to KidCare/FamilyCare Rebate if the family returns a Rebate form and there are no unpaid premiums owed to the Department. Coverage under KidCare/FamilyCare Rebate shall be prospective from the effective date determined according to
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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Section 125.240(e) following receipt by the Department of a completed Rebate Form.

(Source: Added by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

SUBPART C: KIDCARE/FAMILYCARE HEALTH PLAN

Section 125.300 Covered Services

EMERGENCY

a) For children covered under the KidCare/FamilyCare Health Plan, covered health care services shall be the same covered services for children as described at 89 Ill. Adm. Code 140, 77 Ill. Adm. Code 2090, and 59 Ill. Adm. Code 132, except as provided in Section 125.305, and subject to appropriation and any applicable cost sharing requirements defined in Section 125.310 and Section 125.320.

b) For Eligible Adults covered under the KidCare/FamilyCare Health Plan, covered health care services shall be the same covered services for adults as described at 89 Ill. Adm. Code 140, 77 Ill. Adm. Code 2090, and 59 Ill. Adm. Code 132, except as provided at Section 125.305, and subject to appropriation and any applicable cost sharing requirements defined in Section 125.310 and Section 125.320.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.305 Service Exclusions

EMERGENCY

The following health care services will not be covered under the KidCare/FamilyCare Health Plan:

a) Services provided only through a waiver approved under Section 1915(c) of the Social Security Act.

b) Abortion services.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)
Section 125.310 Copayments

a) Copayments may be charged to the Family by a health care professional whenever the service is performed in an office or home setting, except for visits scheduled for well-baby care, well-child care or age-appropriate immunizations. Copayments may also be charged to the Family by hospitals, once per inpatient admission or outpatient encounter (including the emergency room). No copayment is permitted for visits to health care professionals or hospitals made solely for speech, occupational or physical therapy, audiology, radiology or laboratory services (including APL Group 2 procedures). Families with an enrolled individual who is an American Indian or Alaska Native shall not be charged copayments.

b) Copayment requirements are as follows:

1) Practitioner office visit:
   A) KidCare/FamilyCare Share copayment: $2 per visit.
   B) KidCare/FamilyCare Premium copayment: $5 per visit.

2) Home health care visit:
   A) KidCare/FamilyCare Share copayment: $2 per visit.
   B) KidCare/FamilyCare Premium copayment: $5 per visit.

3) Inpatient hospitalization:
   A) KidCare/FamilyCare Share copayment: $2 per admission.
   B) KidCare/FamilyCare Premium copayment: $5 per admission.

4) Outpatient encounter (including the emergency room):
   A) KidCare/FamilyCare Share copayment: $2 per visit.
   B) KidCare/FamilyCare Premium copayment: $5 per visit.

5) Prescription drugs:
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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A) KidCare/FamilyCare Share copayment: $2 for a 1 to 30-day supply on both generic and brand name drugs.

B) KidCare/FamilyCare Premium copayments: $3 for a 1 to 30-day supply on generic drugs or $5 for 1 to 30-day supply on brand name drugs.

6) Nonemergency visit to an emergency room:

A) KidCare/FamilyCare Share copayments: $2 per visit.

B) KidCare/FamilyCare Premium copayment: $25 per visit.

c) The maximum out-of-pocket expense a Family will incur for copayments during a 12-month eligibility period is $100.

d) Once the Family has satisfied the copayment cap, the Family is responsible for submitting receipts, to the Department, documenting the payment of copayments. The Department may return partial documentation received on copayments to the Family.

e) Upon the Department determining that the copayment cap has been satisfied, the following will occur:

1) A notice stating that the copayment cap has been satisfied, and the date satisfied, will be sent to the Family.

2) A message that the copayment cap has been satisfied, and the date satisfied, will be available through the Family's identification card.

3) REV will be updated to reflect that the copayment cap has been reached.

f) Providers will be responsible for collecting copayments under the KidCare/FamilyCare Health Plan.

g) Providers may elect not to charge copayments. If copayments are charged, the copayment must comply with the requirements in this Section.

h) Providers shall be responsible for refunding to the Family copayments they collect after the Family has reached the copayment cap.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

i) The Department will not require providers to deliver services when copayments properly charged under the KidCare/FamilyCare Health Plan are not paid.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.320 Premium Requirements

EMERGENCY

a) Families with individuals enrolled in KidCare Premium pursuant to Section 125.240(c) must pay the premiums established by this Section.

b) The premium amounts are $15 for one individual, $25 for two individuals, $30 for three or more individuals, $35 for four individuals, and $40 for five or more individuals.

c) Premiums are billed by and payable to the Department, or its authorized agent, on a monthly basis.

d) The premium due date will be 26 days after the fifth day of the calendar month preceding the month of coverage.

e) The premium will not change during the eligibility period, unless the Family adds or removes individuals from the coverage.

f) No premiums shall be charged to Families with an enrolled individual who is an American Indian or Alaska Native.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.330 Non-payment of Premium

EMERGENCY

a) KidCare/FamilyCare Health Plan participants will have a grace period through the end of the month following the coverage month to pay the premium.

b) Failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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c) Partial premium payments will not be refunded.

d) Collection action will be initiated by the Department to collect unpaid premiums.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

Section 125.340 Provider Reimbursement

EMERGENCY

a) Providers under this Part shall be subject to approval by the Department to provide health care under the Illinois Public Aid Code.

b) Provider participation under this Part shall be voluntary.

c) Providers under this Part shall be reimbursed in accordance with the established rates of the Department or other appropriate State agency.

d) In addition to reimbursements received from the Department, providers may retain copayments defined in Section 125.310.

e) Providers under this Part shall be prohibited from billing Families covered under the KidCare/FamilyCare Health Plan any difference between the charge amount and the amount paid by the Department, except for copayments as specified in Section 125.310.

f) Providers shall be responsible for refunding to the Family copayments collected in excess of the amounts permitted by this Part.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)

SUBPART D: KIDCARE/FAMILYCARE REBATE

Section 125.400 Minimum Coverage Requirements

EMERGENCY

For an eligible individualchild to participate in KidCare/FamilyCare Rebate, the eligible individualchild must be covered by an insurance plan that offers comprehensive major medical coverage providing benefits for physician services and hospital inpatient services.
Section 125.420  Coverage Verification Process

**EMERGENCY**

a) All applications for participation in KidCare/FamilyCare Rebate must be accompanied by the Department's Insurance Rebate Form.

b) Verification of insurance coverage for the previous coverage period will be required at the annual renewal of KidCare/FamilyCare Rebate.

c) The Department, or its authorized agent, may verify insurance coverage for participants under KidCare/FamilyCare Rebate.

Section 125.430  Provision of Policyholder's Social Security Number

**EMERGENCY**

For an eligible individual child to participate in KidCare/FamilyCare Rebate, the policyholder's valid Social Security Number must be provided.

Section 125.440  KidCare Insurance Rebate

**EMERGENCY**

a) The Rebate will be paid to the individual policyholder insuring the individual child.

b) The Department will issue Rebates on a monthly basis.

c) The total dollar amount of the Rebate paid by the Department per individual child per month shall be the lesser of:

1) The maximum monthly amount set by the Department calculated in accordance with the restrictions in 215 ILCS 106/25 and available appropriations, or
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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2) The policyholder's monthly portion of the premium paid for coverage of
individuals enrolled under KidCare/FamilyCare Rebate.

d) The Department shall set the amount of the Rebate, described in subsection (c) of
this Section, prospectively.

e) To be eligible for payment, a Rebate must equal at least one dollar.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1,
2006, for a maximum of 150 days)

Section 125.445 Rebate Overpayments

a) For purposes of this Part, a Rebate overpayment occurs in any of the following
circumstances:

1) the monthly Rebate paid was higher than the policyholder's portion of the
premium for the individuals enrolled in KidCare/FamilyCare Rebate;

2) the monthly Rebate paid per individual was higher than the maximum
monthly amount set by the Department pursuant to Section 125.440(c)(1);

3) the Rebate was paid for an individual who was incorrectly enrolled
in KidCare/FamilyCare Rebate due to inaccurate or untruthful information
provided on the application; or

4) the Rebate was paid for a period during which the individual was not
covered by private or employer-based insurance meeting the requirements
of Section 125.400; or

5) the Rebate was paid for an Eligible Adult for whom an increase in income
was not reported within ten days after the change and the Family's income
exceeded the upper limit set at Section 125.200(c)(2).

b) Collection action will be initiated by the Department to collect Rebate
overpayments.
c) In cases where the Family notified the Department of the loss of insurance of any enrolled individual or the increase of income with respect to an Eligible Adult within ten days after the change of coverage but past the date when the Department was able to stop issuance or adjust the amount of the next Rebate check, the relevant portion of the Rebate check is not an overpayment.

d) In cases where an individual or a child is covered by private or employer-based insurance (regardless of whether the coverage meets the requirements of Section 125.400) and, due to Department error, Department of Human Services error or inaccurate information from an employer or other third party, an individual or a child is enrolled in Rebate that should not have been or a Rebate payment is higher than it would have been if properly calculated based on accurate information, no overpayment occurs, provided the amount sent in any month does not exceed the maximum monthly amount set by the Department pursuant to Section 125.440(c)(1).

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days)
NOTICE OF EMERGENCY RULES

1) **Heading of the Part:** The Illinois Prescription Drug Discount Program

2) **Code Citation:** 89 Ill. Adm. Code 126

3) **Section Numbers:**
   - 126.10   New Section
   - 126.20   New Section
   - 126.30   New Section
   - 126.40   New Section
   - 126.50   New Section
   - 126.60   New Section
   - 126.70   New Section
   - 126.80   New Section
   - 126.90   New Section
   - 126.100  New Section
   - 126.110  New Section
   - 126.120  New Section

4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13], Public Act 94-86 and Public Act 94-48

5) **Effective Date:** January 1, 2006

6) **If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire:** Not Applicable

7) **Date Filed with the Index Department:** December 30, 2005

8) **A copy of the emergency rules, 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:** These emergency amendments are being filed pursuant to the State's budget implementation plan for fiscal year 2006 under Public Act 94-86. The Illinois Prescription Drug Discount Program, also known as the Illinois Rx Buying Club, is established, effective January 1, 2006. This new program will enable Illinois residents with household incomes that are equal to or less than 300 percent of the Federal Poverty Level to purchase prescription drugs at discounted prices. It is expected that price reductions on prescription drugs will benefit the health and well-being of Illinois residents by providing more affordable access to necessary pharmaceutical products.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY RULES

Section 5-45 of Public Act 94-48 specifically authorizes emergency rulemaking for the implementation of these changes for fiscal year 2006.

10) **Complete Description of the Subjects and Issues Involved**: These emergency amendments respond to Public Act 94-86 under which the Illinois Prescription Drug Discount Program is established, effective January 1, 2006. This new program, also known as the Illinois Rx Buying Club, will enable eligible Illinois residents to purchase prescription drugs at discounted prices. Illinois residents with household incomes that are equal to or less than 300 percent of the Federal Poverty Level are eligible for the new program. An annual enrollment fee will be required from all participants in the program. Authorized pharmacies that participate in the program shall enter into a contract with the Program Administrator. The program allows for negotiation with drug manufacturers for payment rebates. It is expected that price reductions on prescription drugs will benefit the health and well-being of Illinois residents by providing more affordable access to necessary pharmaceutical products.

11) **Are there any other amendments pending on this Part?** No

12) **Statement of Statewide Policy Objectives**: These emergency amendments neither create nor expand any State mandate affecting units of local government.

13) **Information and questions regarding this emergency rulemaking shall be directed to**:

   Joanne Scattoloni  
   Office of the General Counsel, Rules Section  
   Illinois Department of Healthcare and Family Services  
   201 South Grand Avenue East, Third Floor  
   Springfield, Illinois 62763-0002

   (217) 524-0081

The full text of the Emergency Rules begins on the next page:
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY RULES

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER B: ASSISTANCE PROGRAMS

PART 126
THE ILLINOIS PRESCRIPTION DRUG DISCOUNT PROGRAM

SUBPART A: PURPOSE AND DEFINITIONS

Section 126.10 Purpose
EMERGENCY
126.20 Definitions
EMERGENCY

SUBPART B: RESPONSIBILITIES OF THE DEPARTMENT

126.30 Eligibility
EMERGENCY
126.40 Enrollment Fee
EMERGENCY
126.50 Other Administrative Responsibilities of the Department
EMERGENCY

SUBPART C: RESPONSIBILITIES OF THE PROGRAM ADMINISTRATOR

126.60 Eligibility Determination
EMERGENCY
126.70 Enrollment
EMERGENCY
126.80 Re-enrollment
EMERGENCY
126.90 Other Administrative Responsibilities
EMERGENCY
126.100 Termination of Program Administrator
EMERGENCY

SUBPART D: FUNDING

126.110 The Illinois Prescription Drug Discount Program Fund
EMERGENCY
126.120 Discounts


SOURCE: Adopted by emergency rulemaking at 30 Ill. Reg. 563, effective January 1, 2006, for a maximum of 150 days.

SUBPART A: PURPOSE AND DEFINITIONS

Section 126.10 Purpose

This Part implements the Illinois Prescription Drug Discount Program, also known as the Illinois Rx Buying Club, to enable Illinois citizens to purchase prescription drugs at discounted prices.

Section 126.20 Definitions

The following terms have the following meanings:


"Authorized Pharmacy" means any pharmacy registered in this State under the Pharmacy Practice Act of 1987 or approved by the Department of Financial and Professional Regulation and approved by the Department or its Program Administrator.

"AWP" or "Average Wholesale Price" means the amount determined from the latest publication of the Red Book, a universally subscribed pharmacist reference guide annually published by the Hearst Corporation. AWP may also be derived electronically from the drug pricing database synonymous with the latest publication of the Red Book and furnished in the National Drug Data File (NDDF) by First Data Bank (FDB), a service of the Hearst Corporation.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY RULES

"Cardholder" means an eligible Illinois citizen who has enrolled in the program.

"Citizen" means a resident of the State of Illinois.

"Covered medication" means any medication included in the Illinois Prescription Drug Discount Program.

"Department" or "HFS" means the Department of Healthcare and Family Services.

"Director" means the Director of the Department of Healthcare and Family Services.

"Drug Manufacturer" means any entity that is located within or outside Illinois that is engaged in:

- the production, preparation, propagation, compounding, conversion, or processing of prescription drug products covered under the program, either directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or

- the packaging, repackaging, leveling, labeling, or distribution of prescription drug products covered under the program and that elects to provide prescription drugs either directly or under contract with any entity providing prescription drug services on behalf of the State of Illinois.

Drug manufacturer, however, does not include a wholesale distributor of drugs or a retail pharmacy licensed under Illinois law.

"Eligible Enrollee" means an eligible Illinois resident, with a household income equal to or less than 300 percent of the Federal Poverty Level (FPL), and who has paid the enrollment fee.

"Federal Poverty Level" or "FPL" means the Federal Poverty Income Guidelines published annually in the Federal Register.

"Income" means household income equal to or less than 300 percent of the FPL.
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"Participating Pharmacy" means any pharmacy that complies with the requirements of the Illinois Prescription Drug Discount Program.

"Prescription Drug" means any prescribed drug that may be legally dispensed by an authorized pharmacy.

"Program" means the Illinois Rx Buying Club created under the Illinois Prescription Drug Discount Program Act.

"Program Administrator" means the entity that is chosen by the Department to administer the program, consistent with the requirements of the Illinois Prescription Drug Discount Program and these administrative rules in Part 126.

SUBPART B: RESPONSIBILITIES OF THE DEPARTMENT

Section 126.30 Eligibility

Eligibility is limited to:

a) Illinois Residents; and

b) Households with incomes equal to or less than 300 percent of the FPL.

Section 126.40 Enrollment Fee

To participate in the program, an approved applicant must pay an amount determined by the Director of HFS upon enrollment and annually thereafter (Section 35(a) of the Act). The Director may, in his or her discretion, reduce the annual enrollment fee based upon actual administrative costs. The Department shall establish, maintain and account for annual enrollment fees in the Illinois Prescription Drug Discount Program Fund.

Section 126.50 Other Administrative Responsibilities of the Department

a) In discharging its administrative responsibilities pursuant to the Act, the Department will either act as the Program Administrator or enter into a contract with an outside vendor, pursuant to Section 25 of the Act, and/or agreements with State agencies under which those entities will serve as the Program Administrator.
and/or exercise various recordkeeping and other administrative functions. Any contract or agreement must provide for inspection of appropriate records and audits of participating pharmacies or other appropriate measures deemed sufficient by the Director, in his or her discretion, to ensure contract compliance and to determine any fraudulent transactions or practices under the Act. Any contract entered into with outside vendors, must be in compliance with the procedures and requirements set forth in the Illinois Procurement Code.

b) The Department will reimburse the Program Administrator for the cost of cardholder enrollment, pursuant to the contract entered into by the Department and the Program Administrator. The amount of reimbursement will be at a rate to be agreed upon by the Department and the Program Administrator and will be set forth in specificity in the contract. Funds to pay the reimbursement shall come from the enrollment fee and can either be taken from the enrollment fee prior to deposit, or deposited into the Fund and reimbursed back to the Program Administrator, at the discretion of the Director.

c) The Department will, in cooperation with the Program Administrator, establish procedures for properly contracting for pharmacy services and validating compliance of authorized pharmacies with the Act and this Part 126.

d) The Department shall report to the Governor and the General Assembly by March 1 of each year on the administration of the program.

SUBPART C: RESPONSIBILITIES OF THE PROGRAM ADMINISTRATOR

Section 126.60 Eligibility Determination
EMERGENCY

The Program Administrator shall obtain the necessary enrollment information from applicants and shall verify eligibility. Eligibility shall be determined within 30 days after receipt of the application.

Section 126.70 Enrollment
EMERGENCY

The Program Administrator shall:

a) Enroll eligible applicants into the program.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY RULES

1) Other eligible applicants may enroll by mail, facsimile or telephone process.

2) Eligible applicants who enroll by mail or facsimile shall apply on the enrollment form, the content of which shall be approved by the Director, or his or her designee, and which contract may be amended from time to time without further rulemaking.

b) Distribute the identification card to the eligible enrollee.

c) Collect and deposit enrollment fees into the Illinois Prescription Drug Discount Program Fund.

Section 126.80 Re-enrollment
EMERGENCY

The period of enrollment in the program is one year. Cardholders must re-enroll each year by their one-year anniversary date or enrollment will be terminated.

Section 126.90 Other Administrative Responsibilities
EMERGENCY

a) The Program Administrator shall contract with pharmacies electing to participate in the Illinois Rx Buying Club.

b) The contract shall require that a Participating Pharmacy, at a minimum, in Illinois be licensed and in good standing. Participation of any pharmacy shall be terminated by the Department upon a Pharmacy's breach of contract and/or violation of the terms of the Illinois Prescription Drug Discount Program Act.

c) Cardholders may purchase medications in amounts up to a 90-day supply, except as may be necessary for utilization control reasons.

d) The Department and/or Program Administrator may negotiate with one or more Drug Manufacturers for payment rebates. These rebate dollars are to be used to further reduce the prescription cost to the Illinois Prescription Drug Discount Program enrollees, consistent with the requirements of the Illinois Prescription Drug Discount Program.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY RULES

e) The Program Administrator is responsible for providing reports to the Department regarding enrollment participation, prescription costs, savings, pharmacy participation, and any other reports deemed necessary by the Department.

f) The Program Administrator is responsible for providing customer service to cardholders and is responsible for developing, administering and promoting any clinical programs such as disease management, implemented at the discretion of the Director.

Section 126.100 Termination of Program Administrator

EMERGENCY

a) The contract with the Program Administrator may be terminated by the Director, with cause, upon 30 days written notice or, without cause, upon at least 120 days written notice.

b) Upon written notice, determined by the Director to be reasonable under the circumstances requiring modification, the Director may require the Program Administrator to modify the conduct of the Program.

SUBPART D: FUNDING

Section 126.110 The Illinois Prescription Drug Discount Program Fund

EMERGENCY

The Program Administrator shall collect and deposit enrollment fees into the Illinois Prescription Drug Discount Program Fund. At the discretion of the Director, the Program Administrator may deduct an administrative fee from the amount to be deposited. The Department shall separately account for enrollment fees deposited into the Fund.

SUBPART E: DISCOUNTS

Section 126.120 Discounts

EMERGENCY

a) The Program Administrator shall electronically communicate prescription drug discount information to the participating pharmacy.

b) The Program Administrator shall ensure and guarantee that a cardholder will be charged no more than the rate agreed to in the contract.
c) Any manufacturer or group purchasing organization rebate used to provide a discount greater than the agreed to pharmacy rate to the cardholder shall be reimbursed to the participating pharmacy subject to the availability of funds.

d) The cardholder shall receive the greatest discount through the participating pharmacy (at the point of sale). The total amount paid by the available cardholder for any prescription drug under this program shall not exceed the usual and customary charge for the prescription.
NOTICE OF EMERGENCY AMENDMENT

1) Heading of the Part: Medical Payment

2) Code Citation: 89 Ill. Adm. Code 140

3) Section Number: Emergency Action:
   140.405    Repealed


5) Effective Date of Amendment: January 1, 2006

6) If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: Not applicable

7) Date Filed with the Index Department: December 30, 2005

8) A copy of the emergency amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Reason for Emergency: This emergency repeal of the SeniorCare provisions in Part 140 is necessary because SeniorCare has been replaced by the Illinois Cares Rx Program under Public Act 94-86. Section 5-45 of Public Act 94-48 specifically authorizes emergency rulemaking for the implementation of these changes for fiscal year 2006.

10) A Complete Description of the Subjects and Issues Involved: The SeniorCare provisions at Section 140.405 are being repealed because SeniorCare has been replaced by the Illinois Cares Rx Program under Public Act 94-86.

11) Are there any proposed amendments to this Part pending? Yes

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENT

12) **Statement of Statewide Policy Objective:** This emergency amendment neither creates nor expands any State mandate affecting units of local government.

13) **Information and questions regarding this emergency amendment shall be directed to:**

    Joanne Scattoloni  
    Office of the General Counsel, Rules Section  
    Illinois Department of Healthcare and Family Services  
    201 South Grand Ave East, Third Floor  
    Springfield, Illinois 62763-0002  

    217/524-0081

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 d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

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140.3 Covered Services Under Medical Assistance Programs
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140.5 Covered Medical Services Under General Assistance
140.6 Medical Services Not Covered
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AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the
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Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

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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; emergency amendment at 30 Ill. Reg. 573, effective January 1, 2006, for a maximum of 150 days.

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.405 SeniorCare Pharmaceutical Benefit (Repealed)

EMERGENCY

a) Definitions. For purposes of this Section:

"Brand name drug" means those drugs as defined in Section 140.440(g)(3).

"FPL" means the federal poverty income guideline as determined annually by the United States Department of Health and Human Services.

"Generic drug" means those legend drugs as defined in Section 140.440(g)(2).

"Over-the-counter items" means those pharmaceutical items that may be purchased off the shelf by the general public, but for Medicaid-eligible individuals require a prescription.

"Pharmaceutical product" means a brand name drug, a generic drug, or an over-the-counter item.

"Reimbursable amount" means the price payable by the Department or its agent for a pharmaceutical product, as defined in subsection (e) of this Section.

"SeniorCare" means the provision of benefits to individuals qualifying for medical assistance under the provisions of 89 Ill. Adm. Code 120.520.

"SeniorCare benefit amount" means the cumulative sum of the reimbursable amounts for prescribed pharmaceutical products received by an individual eligible for SeniorCare during any State fiscal year.

"SeniorCare rebate" means a SeniorCare benefit in the form of a monetary payment (a monthly payment of $25) made to an individual enrolled in a third-party plan that provides a pharmacy benefit. The payment is made in lieu of the covered services described in this Section.
b) **Covered Services**
Except for an individual who elects to participate in the SeniorCare rebate program, covered services under the SeniorCare program shall consist of pharmaceutical products that are prescribed by licensed medical professionals authorized under State law to issue prescriptions within the scope of their professional practice, and subject to the provisions in Section 140.443.

c) **Co-Payment**
An individual eligible for SeniorCare benefits shall be responsible for payment of applicable co-payments. The co-payment for each brand name drug prescription or generic drug prescription is:

1) For an individual with a household income equal to or greater than the FPL, $1 for each dispensing of a generic drug and $4 for each dispensing of a brand name drug, in addition to any applicable co-payment under subsection (c)(2) of this Section.

2) For all individuals, 20 percent of the reimbursable amount for each prescription dispensed after the SeniorCare benefit amount has exceeded $1,750 for the State fiscal year. If any part of the cost is paid for by Medicare or another third party, the 20 percent is calculated on the net amount paid by the Department.

3) On any prescription for which Medicare is the primary payer, the co-payments described in subsections (c)(1) and (2) of this Section do not apply.

d) **Additional Payment**
An individual eligible for SeniorCare benefits may be responsible for an additional payment to the pharmacy, as determined in subsection (e)(2) or (3) of this Section.

e) **Reimbursable Amount**

1) Except as provided in subsections (c)(2), (3) and (4) of this Section, the reimbursable amount for a pharmaceutical product shall be:

   A) For legend (prescription) drugs, the Department shall pay the lower of:
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i) the pharmacy's prevailing charge to the general public; or

ii) the Department's maximum price plus a dispensing fee of $2.25 for both generic and brand name drugs less applicable co-payments as set forth in subsection (c) of this Section.

B) For generic drugs, the Department's maximum price is calculated as the lowest of:

i) the average wholesale price minus 25 percent; or

ii) the Federal Upper Limit for drugs; or

iii) the State Upper Limit for drugs; or

iv) the average wholesale price for drugs where that price is based upon the actual market wholesale price.

C) For brand name drugs, the Department's maximum price is calculated as the lower of:

i) the average wholesale price minus 14 percent; or

ii) the average wholesale price for drugs where that price is based upon the actual market wholesale price.

D) For those over-the-counter items which are covered, the Department shall pay the lower of:

i) the prevailing charge to the general public; or

ii) the average wholesale price plus 25 percent.

2) If a generic drug is available, based upon the Illinois Formulary for Drug Product Selection Program (77 Ill. Adm. Code 790), and the individual wants the brand name version of the drug, the reimbursable amount shall be that of the generic drug unless the brand name drug is a federally defined narrow therapeutic index drug and substitution is not permitted...
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because the prescribing practitioner has indicated "brand medically necessary" on the prescription. The co-payment amount shall be based upon the generic drug.

3) If a brand name drug is dispensed when the reimbursable amount is that for the generic drug, the individual shall be responsible for paying the difference between the reimbursable amount (based upon the generic drug) and what would have been the reimbursable amount for the brand name drug.

4) If the Department contracts with a third-party to manage some portion of the SeniorCare program, the reimbursable amount shall be the price established by the third party contractor for its pharmacy network or the amount required to be paid to pharmacies by the Department's contract with the third party.

f) Provider Participation
In order to participate in the SeniorCare program, pharmacies shall meet the following requirements:

1) Prior to enrolling with the Department of Public Aid, the pharmacy must possess a current registration issued by the United States Drug Enforcement Administration (see 21 CFR 1301) and, if located in Illinois, a current controlled substances license issued by the Illinois Department of Professional Regulation (68 Ill. Adm. Code 1330) pursuant to the Illinois Controlled Substances Act [720 ILCS 570].

2) The pharmacy must be licensed as required by applicable State and federal laws and regulations.

3) The pharmacy must meet all enrollment criteria set forth by the Department of Public Aid and, if the Department contracts with a third-party to manage some portion of the SeniorCare program, agree to the terms required for participation in that third-party's pharmacy network.

4) The pharmacy must agree to comply with all applicable State and federal laws and regulations.

5) The pharmacy must agree to comply with all applicable Department of Public Aid policies and directives.
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6) The pharmacy must agree not to limit prescriptions filled for individuals receiving care or services from the group practice or long-term care facility to those written by practitioners connected with a group practice or long-term care facility.

7) If it is located in, or administratively associated with a group practice or long-term care facility, the pharmacy must:

A) Provide the same scope of general pharmacy and professional services as does a pharmacy not so affiliated.

B) Be retail in nature and open and accessible to the general public.

8) A hospital pharmacy that provides pharmaceutical services and supplies for inpatients, outpatient clinic patients, or emergency room patients of the hospital shall not enroll as a participating pharmacy unless licensed to provide pharmaceutical services to the general public (division V license).

(Repealed by emergency rulemaking at 30 Ill. Reg. 573, effective January 1, 2006, for a maximum of 150 days)
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1) Heading of the Part: Hospital Services

2) Code Citation: 89 Ill. Adm. Code 148

3) Section Number: Emergency Action:
   148.295 Amendment


5) Effective Date: January 1, 2006

6) If this emergency amendment 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: December 29, 2005

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: This emergency amendment concerning hospital services is being filed pursuant to the enactment of the State's budget plan for fiscal year 2006. The amendment provides additional funding for Critical Hospital Adjustment Payments and will thereby improve access to critical medical services for the Department’s medical assistance clients. Immediate implementation of these changes is necessary to ensure the availability of essential medical care. Section 5-45 of Public Act 94-48 specifically authorizes emergency rulemaking for the implementation of these changes for fiscal year 2006.

10) Complete Description of the Subjects and Issues Involved: This emergency rulemaking provides additional funding under Critical Hospital Adjustment Payments (CHAP) for hospitals that qualify as high volume Medicaid providers. This funding is necessary to ensure continued access to quality health care for the Department’s medical assistance clients. CHAP spending is expected to increase by approximately $2.72 million as a result of these changes.

11) Are there any other amendments pending on this Part? Yes

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148.295 Amendment November 28, 2005 (29 Ill. Reg. 19043)
148.310 Amendment July 1, 2005 (29 Ill. Reg. 9241)
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148.404 New Section July 1, 2005 (29 Ill. Reg. 9241)
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148.412 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.414 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.416 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.418 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.420 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.422 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.424 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.426 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.428 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.430 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.432 New Section July 1, 2005 (29 Ill. Reg. 9241)
148.434 New Section July 1, 2005 (29 Ill. Reg. 9241)

12) Statement of Statewide Policy Objectives: These emergency amendments neither create nor expand any State mandate affecting units of local government.

13) Information and questions regarding this amendment shall be directed to:

Joanne Scattoloni  
Office of the General Counsel, Rules Section  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, Third Floor  
Springfield, Illinois 62763-0002  
(217) 524-0081

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 d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

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emergency amendment at 29 Ill. Reg. 5756, effective April 8, 2005, for a maximum of 150 days; 
early amendment repealed by emergency rulemaking at 29 Ill. Reg. 11622, effective July 
5, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 8363, effective June 1, 2005; 
early amendment at 29 Ill. Reg. 10275, effective July 1, 2005, for a maximum of 150 days; 
early amendment at 29 Ill. Reg. 12568, effective August 1, 2005, for a maximum of 150 
days; early 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; emergency amendment 
at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days.

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.295 Critical Hospital Adjustment Payments (CHAP)

Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding 
count-owned hospitals, as described in Section 148.25(b)(1)(A), unless otherwise noted in this 
Section, and hospitals organized under the University of Illinois Hospital Act, as described in 
Section 148.25(b)(1)(B), for inpatient admissions occurring on or after July 1, 1998, in 
accordance with this Section.

a) Trauma Center Adjustments (TCA)

The Department shall make a TCA to Illinois 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 (IDPH) in accordance with the provisions of 
subsections (a)(1) through (a)(3) of this Section.

1) Level I Trauma Center Adjustment.

A) Criteria. Illinois hospitals that, on the first day of July in the 
CHAP rate period, are recognized as a Level I trauma center by the 
Illinois Department of Public Health shall receive the Level I 
trauma center adjustment.

B) Adjustment. Illinois 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
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Section, shall receive an adjustment of $21,365.00 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 $14,165.00 per Medicaid trauma admission in the CHAP base period.

2) Level II Rural Trauma Center Adjustment. Illinois 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 $11,565.00 per Medicaid trauma admission in the CHAP base period.

3) Level II Urban Trauma Center Adjustment. Illinois urban hospitals, as described in Section 148.25(g)(4), that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of $11,565.00 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)(3) 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)(3) of this Section.

b) Rehabilitation Hospital Adjustment (RHA)
Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as 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), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following three components:
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1) Treatment Component. All hospitals defined in subsection (b) of this Section shall receive $4,215.00 per Medicaid Level I rehabilitation admission in the CHAP base period.

2) Facility Component. All hospitals defined in subsection (b) of this Section shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:

   A) Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $229,360.00 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 $527,528.00 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.

c) Direct Hospital Adjustment (DHA) Criteria

1) Qualifying Criteria
Hospitals may qualify for the DHA under this subsection (c) under the following categories:

   A) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:

      i) were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999 and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;
ii) were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999 and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

iii) were county owned hospitals as defined in 89 Ill. Adm. Code 148.25(b)(1)(A), and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.

B) Illinois hospitals located outside of HSA 6 that had an MIUR greater than 60 percent on July 1, 1999 and an average length of stay less than ten days. The following hospitals are excluded from qualifying under this subsection (c)(1)(B): children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

C) Children's hospitals, as defined under 89 Ill. Adm. Code 149.50(c)(3), on July 1, 1999.

D) Illinois teaching hospitals, with more than 40 graduate medical education programs on July 1, 1999, not qualifying in subsection (c)(1)(A), (B), or (C) of this Section.

E) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsection (c)(1)(A), (B), (C) or (D) of this Section, all other hospitals located in Illinois that had an MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999 and provided more than 15,000 Total days.

F) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A), (B), (C), (D), or (E) of this Section, all other hospitals that had an MIUR greater than 40 percent on July 1, 1999 and provided more than 7,500 Total days and provided obstetrical care as of July 1, 2001.
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G) Illinois teaching hospitals with 25 or more graduate medical education programs on July 1, 1999, that are affiliated with a Regional Alzheimer's Disease Assistance Center as designated by the Alzheimer's Disease Assistance Act [410 ILCS 405/4], that had an MIUR less than 25 percent on July 1, 1999 and provided 75 or more Alzheimer days for patients diagnosed as having the disease.

H) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(G) of this Section, all other hospitals that had an MIUR greater than 50 percent on July 1, 1999.

I) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsections (c)(1)(A) through (c)(1)(H) of this Section, all other hospitals that had an MIUR greater than 23 percent on July 1, 1999, 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.

2) DHA Rates

A) For hospitals qualifying under subsection (c)(1)(A) of this Section, the DHA rates are as follows:

i) Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive $69.00 per day for hospitals that do not provide obstetrical care and $105.00 per day for hospitals that do provide obstetrical care.

ii) Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will receive $105.00 per day for hospitals that do
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not provide obstetrical care and $142.00 per day for hospitals that do provide obstetrical care.

iii) Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviation above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive $124.00 per day for hospitals that do not provide obstetrical care and $160.00 per day for hospitals that do provide obstetrical care.

iv) Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive $142.00 per day for hospitals that do not provide obstetrical care and $179.00 per day for hospitals that do provide obstetrical care.

B) Hospitals qualifying under subsection (c)(1)(A) of this Section will also receive the following rates:

i) County owned hospitals as defined in Section 148.25 with more than 30,000 Total days will have their rate increased by $455.00 per day.

ii) Hospitals that are not county owned with more than 30,000 Total days will have their rate increased by $330.00 per day.

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.
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vii) Hospitals with an average length of stay less than 3.9 days will have their rate increased by $41.00 per day.

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 $227.00 per day.

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 $182.25 per day.

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 $281.00 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 $98.00 per day.

C) Hospitals qualifying under subsection (c)(1)(B) of this Section will receive the following rates:

i) Qualifying hospitals will receive a rate of $421.00 per day.

ii) Qualifying hospitals with more than 1,500 Obstetrical days will have their rate increased by $369.00 per day.

D) Hospitals qualifying under subsection (c)(1)(C) of this Section will receive the following rates:

i) Hospitals will receive a rate of $28.00 per day.

ii) Hospitals located in Illinois and outside of HSA 6 that have an MIUR greater than 60 percent will have their rate increased by $55.00 per day.
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.

iv) Hospitals that are not located in Illinois that have an MIUR greater than 45 percent will have their rate increased by $32.00 per day for hospitals that have fewer than 4,000 Total days; or $246.00 per day for hospitals that have more than 4,000 Total days but fewer than 8,000 Total days; or $178.00 per day for hospitals that have more than 8,000 Total days.

v) Hospitals with more than 3,200 Total admissions will have their rate increased by $328.00 per day.

E) Hospitals qualifying under subsection (c)(1)(D) of this Section will receive the following rates:

i) Hospitals will receive a rate of $41.00 per day.

ii) Hospitals with an MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $14.00 per day.

iii) Hospitals with an MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $87.00 per day.

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.

F) Hospitals qualifying under subsection (c)(1)(E) of this Section will receive $188.00 per day.

G) Hospitals qualifying under subsection (c)(1)(F) of this Section will receive a rate of $55.00 per day.

H) Hospitals that qualify under subsection (c)(1)(G) of this Section will receive the following rates:
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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 $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 share adjustments for hospitals qualifying under subsection (c)(1)(A)(iii) of this Section.

3) DHA Payments

A) Payments under this subsection (c) will be made at least quarterly, beginning with the quarter ending December 31, 1999.

B) Payment rates will be multiplied by the Total days.

C) Total Payment Adjustments

i) For the CHAP rate period occurring in State fiscal year 20062004, total payments will equal the methodologies described in subsection (c)(2) of this Section. For the period January 1, 2006April 1, 2004, to June 30, 20062004, payment will equal the State fiscal year 20062004 amount less the amount the hospital received under DHA for the quarters ending September 30, 20062003, and December 31, 20062003, and March 31, 2004.
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ii) For CHAP rate periods occurring after State fiscal year 2006, total payments will equal the methodologies described in subsection (c)(2) of this Section.

d) Rural Critical Hospital Adjustment Payments (RCHAP)
RCHAP shall be made to rural hospitals, as described in 89 Ill. Adm. Code 140.80(j)(1), for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $367,179.00 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 $1,367.00 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 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.

g) Critical Hospital Adjustment Payment Definitions
The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:

1) "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates
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2) "CHAP base period" means State Fiscal Year 1994 for CHAP calculated for the July 1, 1995 CHAP rate period; State Fiscal Year 1995 for CHAP calculated for the July 1, 1996 CHAP rate period; etc.

3) "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.

4) "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, and as defined in Section 148.120(k)(5), plus the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120(k)(6), as of July 1, 1999.

5) "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.

6) "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, 854.16, 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.

7) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.
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8) "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.

9) "Medicaid trauma admission" means those claims billed as 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: 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.

10) "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.

11) "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.

12) "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.
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13) "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.

14) "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.

15) "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 by emergency rulemaking at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days)
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENT

1) **Heading of the Part:** Long Term Care Reimbursement Changes

2) **Code Citation:** 89 Ill. Adm. Code 153

3) **Section Number:** 153.125  **Emergency Action:** Amendment

4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13], Public Act 94-697 and Public Act 94-48

5) **Effective Date:** January 1, 2006

6) **If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire:** Not Applicable

7) **Date Filed with the Index Department:** December 29, 2005

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:** This emergency amendment is being filed pursuant to the State’s budget implementation plan for fiscal year 2006 under Public Act 94-697. Rates taking effect on January 1, 2006 for ICF/MR facilities will be increased by 2.69 percent, and for developmental training providers will be increased by 3 percent, over the rates in effect on December 31, 2005. Section 5-45 of Public Act 94-48 specifically authorizes emergency rulemaking for the implementation of these changes for fiscal year 2006.

10) **Complete Description of the Subjects and Issues Involved:** Pursuant to Public Act 94-697, this emergency amendment provides a 2.69 percent rate increase for intermediate care facilities for persons with developmental disabilities (ICF/MR) and a 3 percent rate increase for developmental training (DT) agencies, effective January 1, 2006. This change will result in an annual cost increase for the Department of Human Services of approximately $9.5 million for ICFs/MR and $2.2 million for DT agencies.

11) **Are there any other amendments pending on this Part?** No

12) **Statement of Statewide Policy Objectives:** These emergency amendments neither create nor expand any State mandate affecting units of local government.
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENT

13) **Information and questions regarding this amendment shall be directed to:**

   Joanne Scattoloni  
   Office of the General Counsel, Rules Section  
   Illinois Department of Healthcare and Family Services  
   201 South Grand Avenue East, Third Floor  
   Springfield, Illinois  62763-0002  

   (217) 524-0081

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 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
153.150 Quality Assurance Review (Repealed)


SOURCE: Emergency rules adopted at 18 Ill. Reg. 2159, effective January 18, 1994, for maximum of 150 days; adopted at 18 Ill. Reg. 10154, effective June 17, 1994; emergency amendment at 18 Ill. Reg. 11380, effective July 1, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16669, effective November 1, 1994; emergency amendment at 19 Ill. Reg. 10245, effective June 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16281, effective November 27, 1995; emergency amendment at 20 Ill. Reg. 9306, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 14840, effective November 1, 1996; emergency amendment at 21 Ill. Reg. 9568, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13633, effective October 1, 1997; emergency amendment at 22 Ill. Reg. 13114, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16285, effective August 28, 1998; amended at 22 Ill. Reg. 19872, effective October 30, 1998; emergency amendment at 23 Ill. Reg. 8229, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12794, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13638, effective November 1, 1999; emergency amendment at 24 Ill. Reg. 10421, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15071, effective October 1, 2000; emergency amendment at 25 Ill. Reg. 8867, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 14952, effective November 1, 2001; emergency amendment at 26 Ill. Reg. 6003, effective April 11, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 12791, effective August 9, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11087, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17817, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 11088, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18880, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 10218, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 15584, effective
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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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.

Section 153.125 Long Term Care Facility Rate Adjustments

Notwithstanding the provisions set forth in Section 153.100, long term care facility (SNF/ICF and ICF/MR) rates established on July 1, 1996, shall be increased by 6.8 percent for services provided on or after January 1, 1997.

Notwithstanding the provisions set forth in Section 153.100, long term care facility (SNF/ICF and ICF/MR) rates and developmental training rates established on July 1, 1998, for services provided on or after that date, shall be increased by three percent. For nursing facilities (SNF/ICF) only, $1.10 shall also be added to the nursing component of the rate.

Notwithstanding the provisions set forth in Section 153.100, long term care facility (SNF/ICF and ICF/MR) rates and developmental training rates established on July 1, 1999, for services provided on or after that date, shall include:

1) an increase of 1.6 percent for SNF/ICF, ICF/MR and developmental training rates;
2) an additional increase of $3.00 per resident day for ICF/MR rates; and
3) an increase of $10.02 per person, per month for developmental training rates.

Notwithstanding the provisions set forth in Section 153.100, SNF/ICF rates shall be increased by $4.00 per resident day for services provided on or after October 1, 1999.

Notwithstanding the provisions set forth in Section 153.100, SNF/ICF, ICF/MR and developmental training rates shall be increased 2.5 percent per resident day for services provided on or after July 1, 2000.

Notwithstanding the provisions set forth in Section 153.100, nursing facility
NOTICE OF EMERGENCY AMENDMENT

(SNF/ICF) rates effective on July 1, 2001, shall be computed using the most recent cost reports on file with the Department no later than April 1, 2000, updated for inflation to January 1, 2001.

1) The Uniform Building Value shall be as defined in 89 Ill. Adm. Code 140.570(b)(10), except that, as of July 1, 2001, the definition of current year is the year 2000.

2) The real estate tax bill that was due to be paid in 1999 by the nursing facility shall be used in determination of the capital component of the rate. The real estate tax component shall be removed from the capital rate if the facility's status changes so as to be exempt from assessment to pay real estate taxes.

3) For rates effective July 1, 2001, only, rates shall be the greater of the rate computed for July 1, 2001, or the rate effective on June 30, 2001.

4) All accounting records and other documentation necessary to support the costs and other information reported on the cost report to be used in accordance with rate setting under Section 153.125(f) shall be kept for a minimum of two years after the Department's final payment using rates that were based in part on that cost report.

g) Notwithstanding the provisions set forth in Section 153.100, intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled nursing facilities for persons under 22 years of age (SNF/Ped), shall receive an increase in rates for residential services equal to a statewide average of 7.85 percent. Residential rates taking effect March 1, 2001, for services provided on or after that date, shall include an increase of 11.01 percent to the residential program rate component and an increase of 3.33 percent to the residential support rate component, each of which shall be adjusted by the geographical area adjuster, as defined by the Department of Human Services (DHS).

h) For developmental training services provided on or after March 1, 2001, for residents of long term care facilities, rates shall include an increase of 9.05 percent and rates shall be adjusted by the geographical area adjuster, as defined by DHS.

i) Notwithstanding the provisions set forth in Section 153.100, daily rates for intermediate care facilities for persons with developmental disabilities (ICF/MR),
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENT

including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be increased by 2.247 percent for services provided during the period beginning on April 11, 2002, and ending on June 30, 2002.

j) Notwithstanding the provisions set forth in Section 153.100, daily rates effective on July 1, 2002, for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be reduced to the level of the rates in effect on April 10, 2002.

k) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates effective on July 1, 2002 will be 5.9 percent less than the rates in effect on June 30, 2002.

l) Notwithstanding the provisions set forth in Section 153.100, daily rates effective on July 1, 2003, for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be increased by 3.59 percent.

m) Notwithstanding the provisions set forth in Section 153.100, developmental training rates effective on July 1, 2003, shall be increased by 4 percent.

n) Notwithstanding the provisions set forth in Section 153.100, pending the approvals described in this subsection (n), nursing facility (SNF/ICF) rates effective July 1, 2004, shall be 3.0 percent greater than the rates in effect on June 30, 2004. The increase is contingent on approval of both the payment methodologies required under Article 5A-12 of the Public Aid Code [305 ILCS 5/5A-12] and the waiver granted under 42 CFR 433.68.

o) Notwithstanding the provisions set forth in Section 153.100, the "Original Building Base Cost" for nursing facilities (SNF/ICF) which have been rented continuously from an unrelated party since prior to January 1, 1978, effective on July 1, 2004, shall be added to the capital rate calculation using the most recent cost reports on file with the Department no later than June 30, 2004. The "Original Building Base Cost" as defined in 89 Ill. Adm. Code 140.570 shall be calculated from the original lease information that is presently on file with the Department. This original lease information will be used to capitalize the oldest available lease payment from the unrelated party lease that has been in effect since prior to January 1, 1978, and continued to be in effect on December 31, 1999. Before the lease payment is capitalized, a 15 percent portion will be
removed from the oldest available lease payment for movable equipment costs. After the lease payment is capitalized, a portion of the capitalized amount will be removed for land cost. The land cost portion is 4.88 percent. The remaining amount will be the facility's building cost. The construction/acquisition year for the building will be the date the pre-1978 lease began. The allowable cost of subsequent improvements to the building will be included in the original building base cost. The original building base cost will not change due to sales or leases of the facility after January 1, 1978.

p) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates effective on January 1, 2005 will be 3.0 percent more than the rates in effect on December 31, 2004.

q) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates shall be increased by the difference between a facility's per diem property, liability and malpractice insurance costs as reported in the cost report that was filed with the Department and used to establish rates effective July 1, 2001, and those same costs as reported in the facility's 2002 cost report. These costs shall be passed through to the facility without caps or limitations.

r) Notwithstanding the provisions set forth in Section 153.100, daily rates effective on January 1, 2006, for intermediate care facilities for persons with developmental disabilities (ICF/MR) including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be increased by 2.69 percent.

s) Notwithstanding the provisions set forth in Section 153.100, developmental training rates for intermediate care facilities for persons with developmental disabilities (ICF/MR) including skilled long term care facilities for persons under 22 years of age (SNF/Ped), effective on January 1, 2006 shall be increased by 3 percent.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 616, effective January 1, 2006, for a maximum of 150 days)
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

1) **Heading of the Part**: Pay Plan

2) **Code Citation**: 80 Ill. Adm. Code 310

3) **Section Numbers**:
   - 310.410 Amendment
   - 310.Appendix A Table W Amendment

4) **Reference to the Specific State or Federal Court Order, Federal Rule or Statute which Requires this Peremptory Rulemaking**:
   The Department of Central Management Services (CMS) is amending the Pay Plan 80 Ill. Adm. Code 310.410 and 310.Appendix A Table W to reflect three Memoranda of Understanding between the Department of Central Management Services and the American Federation of State, County and Municipal Employees (AFSCME).

   One Memorandum of Understanding was signed December 5, 2005 and took effect December 1, 2005 when the Civil Service Commission approved the new Aircraft Pilot II – Dual Rating classification.

   Two other Memoranda of Understanding were signed December 16, 2005 and affected the existing Human Rights Specialist III and the Volunteer Services Coordinator III classifications.

5) **Statutory Authority**: Authorized by Sections 8 and 8a of the Personnel Code [20 ILCS 415/8 and 20 ILCS 415/8a].

6) **Effective Date**: December 28, 2005

7) **A Complete Description of the Subjects and Issues Involved**:
   CMS is amending the Pay Plan (80 Ill. Adm. Code 310) 310.410 Jurisdiction by removing the Human Rights Specialist III and the Volunteer Services Coordinator III classification titles from the Merit Compensation System.

   CMS is amending the Pay Plan (80 Ill. Adm. Code 310) 310.Appendix A Table W to include the new Aircraft Pilot II – Dual Rating classification title, its title code 00957, its bargaining unit RC-062, and its pay grade 23, the Human Rights Specialist III classification title, its title code 19780, its bargaining unit RC-062, and its pay grade 18, and the Volunteer Services Coordinator III classification title, its title code 48483, its bargaining unit RC-062, and its pay grade 18, and remove Aircraft Pilot II Option C classification title, its title code 00956, its bargaining unit RC-062, and its pay grade 23.
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

8) Does this rulemaking contain an automatic repeal date? No

9) Date filed with the Index Department: December 28, 2005

10) This and other Pay Plan amendments are available in the Division of Technical Services of the 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 amendments pending on this Part?

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<th>Proposed Action</th>
<th>Ill. Reg. Citation</th>
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<td>310.50</td>
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<td>310.APPENDIX D</td>
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13) Statement of Statewide Policy Objectives: These amendments to the Pay Plan affect only the employees subject to the Personnel Code and do not set out any guidelines that affect local or other jurisdictions in the State.

14) Information and questions regarding these peremptory amendments shall be directed to:

Mr. Jason Doggett
Acting 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

(217) 782-7964
Fax: (217) 524-4570
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

The full text of the Peremptory Amendments begins on the next page:
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE B: PERSONNEL RULES, PAY PLANS, AND
POSITION CLASSIFICATIONS
CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 310
PAY PLAN

SUBPART A: NARRATIVE

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SUBPART B: SCHEDULE OF RATES

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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
310.420 Objectives
310.430 Responsibilities
310.440 Merit Compensation Salary Schedule
310.450 Procedures for Determining Annual Merit Increases
310.455 Intermittent Merit Increase
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 Guidechart for Fiscal Year 2006
310.550 Fiscal Year 1985 Pay Changes in Merit Compensation System, effective July 1, 1984 (Repealed)

310 APPENDIX A Negotiated Rates of Pay
310.TABLE A HR-190 (Department of Central Management Services – State of Illinois Building – SEIU) (Repealed)
310.TABLE B HR-200 (Department of Labor – Chicago, Illinois – SEIU) (Repealed)
310.TABLE C RC-069 (Firefighters, AFSCME) (Repealed)
310.TABLE D HR-001 (Teamsters Local #726)
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)
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

310.TABLE I  RC-009 (Institutional Employees, AFSCME)
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310.TABLE Q  RC-033 (Meat Inspectors, IFPE)
310.TABLE R  RC-042 (Residual Maintenance Workers, AFSCME)
310.TABLE S  HR-012 (Fair Employment Practices Employees, SEIU)
            (Repealed)
310.TABLE T  HR-010 (Teachers of Deaf, IFT)
310.TABLE U  HR-010 (Teachers of Deaf, Extracurricular Paid Activities)
310.TABLE V  CU-500 (Corrections Meet and Confer Employees)
310.TABLE W  RC-062 (Technical Employees, AFSCME)
310.TABLE X  RC-063 (Professional Employees, AFSCME)
310.TABLE Y  RC-063 (Educators, AFSCME)
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310.TABLE AA NR-916 (Department of Natural Resources, Teamsters)
310.TABLE AB VR-007 (Plant Maintenance Engineers, Operating Engineers)
            (Repealed)
310.APPENDIX B Schedule of Salary Grades – Monthly Rates of Pay for Fiscal Year 2006
310.APPENDIX C Medical Administrator Rates for Fiscal Year 2006
310.APPENDIX D Merit Compensation System Salary Schedule for Fiscal Year 2006
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 for Fiscal Year 2006

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

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

Section 310.410 Jurisdiction

The Merit Compensation System shall apply to all classes of positions designated below and in the ALPHABETIC INDEX OF POSITION TITLES. Also see Section 310.495 for the application of the Merit Compensation System for those Broad-Band titles listed with their salary ranges in Appendix G.

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<tr>
<td>Activity Therapist Supervisor</td>
<td>00163</td>
<td>MC-07</td>
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<td>Actuary III</td>
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<td>Administrative Assistant II</td>
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<td>MC-06</td>
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<td>Agricultural Marketing Representative</td>
<td>00810</td>
<td>MC-05</td>
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<td>Assignment Coordinator</td>
<td>01530</td>
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<td>Assistant Automotive Shop Supervisor</td>
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<td>MC-03</td>
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<td>Automotive Shop Supervisor</td>
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<td>MC-07</td>
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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

Waterways Construction Supervisor II 49062 MC-07

(Source: Peremptory amendment at 30 Ill. Reg. 623, effective December 28, 2005)
### NOTICE OF PEREMPTORY AMENDMENTS

**Section 310. APPENDIX A  Negotiated Rates of Pay**

**Section 310. TABLE W  RC-062 (Technical Employees, AFSCME)**

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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Systems Specialist I
Information Technology/Communication 21217 RC-062 24

Systems Specialist II
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 21610 RC-062 13

Trainee
Insurance Performance Examiner I 21671 RC-062 14
Insurance Performance Examiner II 21672 RC-062 16
Insurance Performance Examiner III 21673 RC-062 20
Intermittent Unemployment Insurance 21689 RC-062 12H

Representative
Internal Auditor I 21721 RC-062 17
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
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 Sales Representative 24515 RC-062 16
Management Operations Analyst I 25541 RC-062 18
**DEPARTMENT OF CENTRAL MANAGEMENT SERVICES**

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Public Aid Staff Development Specialist II 36072 RC-062 17
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Railroad Safety Specialist III 37603 RC-062 23
Railroad Safety Specialist IV 37604 RC-062 25
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Real Estate Professions Examiner 37760 RC-062 22
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Rehabilitation Counselor 38145 RC-062 17
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Rehabilitation Workshop Supervisor II 38195 RC-062 14
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Research Scientist I 38231 RC-062 13
Research Scientist II 38232 RC-062 16
Research Scientist III 38233 RC-062 20
Resource Planner I 38281 RC-062 17
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Resource Planner III 38283 RC-062 22
Revenue Auditor I (IL) 38371 RC-062 16
Revenue Auditor I (states other than IL, CA) 38371 RC-062 19
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

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Revenue Auditor II (IL)  38372  RC-062  19
Revenue Auditor II (states other than IL, CA or NJ)  38372  RC-062  22
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Revenue Auditor III (states other than IL, CA or NJ)  38373  RC-062  24
Revenue Auditor III (CA or NJ)  38373  RC-062  26
Revenue Auditor Trainee  38375  RC-062  12
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Revenue Collection Officer II  38402  RC-062  17
Revenue Collection Officer III  38403  RC-062  19
Revenue Collection Officer Trainee  38405  RC-062  12
Revenue Computer Audit Specialist (IL)  38425  RC-062  23
Revenue Computer Audit Specialist (states other than IL, CA or NJ)  38425  RC-062  25
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Revenue Senior Special Agent  38557  RC-062  23
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Revenue Special Agent Trainee  38565  RC-062  14
Revenue Tax Specialist I  38571  RC-062  12
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Revenue Tax Specialist III  38573  RC-062  17
Revenue Tax Specialist Trainee  38575  RC-062  10
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  16
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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State Police Field Specialist II 42002 RC-062 20
Statistical Research Specialist I 42741 RC-062 12
Statistical Research Specialist II 42742 RC-062 14
Statistical Research Specialist III 42743 RC-062 17
Storage Tank Safety Specialist 43005 RC-062 18
Telecommunications Specialist 45295 RC-062 15
Telecommunications Systems Analyst 45308 RC-062 17
Telecommunications Systems Technician I 45312 RC-062 10
Telecommunications Systems Technician II 45313 RC-062 13
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
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
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Weatherization Specialist Trainee 49105 RC-062 12

Effective July 1, 2005
Bargaining Unit: RC-062

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Grade  Plan  S T E P S
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES  

NOTICE OF PROPOSED AMENDMENTS  

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

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Bargaining Unit: RC-062

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**DEPARTMENT OF CENTRAL MANAGEMENT SERVICES**

**NOTICE OF PEREMPTORY AMENDMENTS**

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

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(Source: Peremptory amendment at 30 Ill. Reg. 623, effective December 28, 2005)
a) **Part (Heading and Code Citation):** Public Schools Evaluation, Recognition and Supervision; 23 Ill. Adm. Code 1

1) **Rulemaking:**

   A) **Description:** The portions of Part 1 that discuss the requirement for daily physical education will be amended in response to P.A. 94-198. The material on the accountability system will be revised to reflect any formal determination by the United States Department of Education on the calculation of adequate yearly progress under P.A. 94-666 and to provide a fuller description of the Student Information System.

   B) **Statutory Authority:** 105 ILCS 5/ 2-3.6

   C) **Scheduled meeting/hearing date:** To be announced

   D) **Date agency anticipates First Notice:** May 5, 2006

   E) **Effect on small businesses, small municipalities, or not-for-profit corporations:** None

   F) **Agency contact person for information:**

   Sally Vogl  
   Agency Rules Coordinator  
   Illinois State Board of Education  
   100 North First Street  
   Springfield, Illinois 62777  
   217/782-5270

   G) **Related rulemakings and other pertinent information:** None

b) **Part (Heading and Code Citation):** Certification; 23 Ill. Adm. Code 25.

1) **Rulemaking:**

   A) **Description:** Further amendments to Part 25 may be developed as a result of the ongoing review of ISBE’s rules.

   B) **Statutory Authority:** 105 ILCS 5/ 2-3.6, 14C-8, and Art. 21
STATE BOARD OF EDUCATION
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C) Scheduled meeting/hearing date: To be announced

D) Date agency anticipates First Notice: June 2, 2006

E) Effect on small businesses, small municipalities, or not-for-profit corporations: None

F) Agency contact person for information:

Sally Vogl
Agency Rules Coordinator
Illinois State Board of Education
100 North First Street
Springfield, Illinois 62777
217/782-5270

G) Related rulemakings and other pertinent information: None

c) Part (Heading and Code Citation): Health/Life Safety Code for Public Schools; 23 Ill. Adm. Code 180

1) Rulemaking:

A) Description: Part 180 will be amended to incorporate requirements for the documentation of school inspections and reviews of school plans, as called for in P.A. 94-225.

B) Statutory Authority: 105 ILCS 5/2-3.127

C) Scheduled meeting/hearing date: To be announced

D) Date agency anticipates First Notice: March 31, 2006

E) Effect on small businesses, small municipalities, or not-for-profit corporations: None

F) Agency contact person for information:

Sally Vogl
STATE BOARD OF EDUCATION

JANUARY 2006 REGULATORY AGENDA

Agency Rules Coordinator
Illinois State Board of Education
100 North First Street
Springfield, Illinois  62777
217/.782-5270

G) Related rulemakings and other pertinent information:  None

d) Part (Heading and Code Citation):  Special Education; 23 Ill. Adm. Code 226

1) Rulemaking:
   A) Description:  The set of rules will be rewritten as necessary to reflect the reauthorization of the federal Individuals with Disabilities Education Improvement Act and the provisions of P.A. 94-376, as well as to streamline it as much as possible.
   B) Statutory Authority:  105 ILCS 5/Art. 14 and 2-3.6
   C) Scheduled meeting/hearing date:  To be announced
   D) Date agency anticipates First Notice:  March 3, 2006
   E) Effect on small businesses, small municipalities, or not-for-profit corporations:  None
   F) Agency contact person for information:
      Sally Vogl
      Agency Rules Coordinator
      Illinois State Board of Education
      100 North First Street
      Springfield, Illinois  62777
      217/782-5270
   G) Related rulemakings and other pertinent information:  None

e) Part (Heading and Code Citation):  Gifted Education; 23 Ill. Adm. Code 227

1) Rulemaking:
STATE BOARD OF EDUCATION

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A) Description: A new Part 227 will be developed to provide for the approval of gifted education programs in accordance with P.A. 94-151; promulgation of the rules will be contingent upon the availability of funding.

B) Statutory Authority: 105 ILCS 5/Art. 14A and 2-3.6

C) Scheduled meeting/hearing date: To be announced

D) Date agency anticipates First Notice: March 3, 2006

E) Effect on small businesses, small municipalities, or not-for-profit corporations: None

F) Agency contact person for information:

Sally Vogl
Agency Rules Coordinator
Illinois State Board of Education
100 North First Street
Springfield, Illinois  62777
217/782-5270

G) Related rulemakings and other pertinent information: None

f) Part (Heading and Code Citation): Providers of Supplemental Educational Services; 23 Ill. Adm. Code 675

1) Rulemaking:

A) Description: This set of rules will be amended to refine the evaluation process, ethics code, and financial reporting requirements based on the experience gained during the implementation of the relevant emergency rules in 2005.

B) Statutory Authority: 105 ILCS 5/2-3.6

C) Scheduled meeting/hearing date: To be announced
D) Date agency anticipates First Notice: March 31, 2006

E) Effect on small businesses, small municipalities, or not-for-profit corporations: None

F) Agency contact person for information:

Sally Vogl
Agency Rules Coordinator
Illinois State Board of Education
100 North First Street
Springfield, Illinois  62777
217/782-5270

G) Related rulemakings and other pertinent information: None

Part (Heading and Code Citation): School Emergency and Crisis Response Plans; 29 Ill. Adm. Code 1500

1) Rulemaking:

A) Description: This set of rules will establish the requirements contemplated by P.A. 94-600 for the annual review of schools’ plans for responding to emergencies. New Part 1500 will be promulgated as joint rules with the Office of the State Fire Marshal.

B) Statutory Authority: 105 ILCS 128/40

C) Scheduled meeting/hearing date: To be announced

D) Date agency anticipates First Notice: March 31, 2006

E) Effect on small businesses, small municipalities, or not-for-profit corporations: None

F) Agency contact person for information:

Sally Vogl
Agency Rules Coordinator
Illinois State Board of Education
STATE BOARD OF EDUCATION

JANUARY 2006 REGULATORY AGENDA

100 North First Street
Springfield, Illinois 62777
217/782-5270

G) Related rulemakings and other pertinent information: None
a) Part(s) (Heading and Code Citations): Suspension or Revocation of Driver’s Licenses/Permits for Fictitious or Unlawfully Altered Person-with Disabilities License Plate or Parking Decal or Device or Fraudulent Person-with-Disabilities License Plate or Parking Decal or Device; 92 Ill. Admin. Code 1040.33

1) Rulemaking:

A) Description: This amendment will address the requirements of P.A. 94-0619, which requires the Secretary of State to suspend or revoke the driving privileges of an individual who misuses the disability license plate or parking decal or device for purposes of parking in a location reserved for disabled persons when the vehicle is not transporting the authorized holder of the disability license plate or parking decal or device.

B) Statutory Authority: 6 25 ILCS 5/11-1301.3

C) Scheduled Meeting/Hearing Dates: None

D) Date Agency Anticipates First Notice: January 2006

E) Impact on Small Businesses, Small Municipalities or Not for Profit Corporations: None

F) Agency Contact Person for Information:

Illinois Secretary of State
Driver Services Department
Jo Ann Wilson, Legislative Liaison
C/o Director’s Office
2701 South Dirksen Parkway
Springfield IL 62723
217-785-1441 Fax 217-557-1033
jwilson@ilsos.net

G) Related Rulemakings and Other Pertinent Information: None

b) Part(s) (Heading and Code Citation): Illinois Business Brokers Act of 1995; 14 Ill. Admin. Code 140
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

1) Rulemaking:

A) **Description:** Amend rules and draft rules generally to conform regulations to legislative enactments.

B) **Statutory Authority:** Illinois Business Broker Act, 815 ILCS 307/10-1

C) **Scheduled Meeting/Hearing Dates:** None

D) **Date Agency Anticipates First Notice:** Unknown

E) **Impact on Small Business, Small Municipalities or Not for Profit Corporations:** Unknown

F) **Agency Contact Person for Information:**

   Tanya Solov, Director
   Illinois Securities Department
   Office of the Secretary of State
   69 W. Washington Street, Suite 1220
   Chicago IL 60602
   312-793-3384 Fax 312-793-1202
   tsolov@ilsos.net

G) **Related Rulemaking and Other Pertinent Information:** None

c) **Part(s) (Heading and Code Citation):** Illinois Securities Law of 1953; 14 Ill. Admin. Code 130

1) Rulemaking:

A) **Description:** Amend and draft rules generally to conform regulations to state and federal legislative enactments and rules of the US Securities and Exchange Commission.

B) **Statutory Authority:** Illinois Securities Law of 1953, 815 ILCS 5/1

C) **Scheduled Meeting/Hearing Dates:** None

D) **Date the Agency Anticipates First Notice:** Unknown
E) Impact on Small Business, Small Municipalities or Not For Profit Corporations: Unknown

F) Agency Contact Person for Information:

   Tanya Solov, Director
   Illinois Securities Department
   Office of the Secretary of State
   69 W. Washington Street, Suite 1220
   Chicago IL  60602
   312-793-3384  Fax 312-793-1202
   tsolov@ilsos.net

G) Related Rulemaking and Other Pertinent Information: None

d) Part(s) (Heading and Code Citation): Illinois Business Opportunity Sales Law of 1995; 14 Ill. Admin. Code 135

1) Rulemaking:

   A) Description: Amend and draft rules generally to conform regulations to legislative enactments.


   C) Schedule Meeting/Hearing Dates: None

   D) Date the Agency Anticipates First Notice: Unknown

   E) Impact on Small Business, Small Municipalities or Not For Profit Corporations: Unknown

   F) Agency Contact Person for Information:

       Tanya Solov, Director
       Illinois Securities Department
       Office of the Secretary of State
       69 W. Washington Street, Suite 1220
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

Chicago IL  60602
312-793-3384  Fax:  312-7930-1202
tsolov@ilsos.net

G) Related Rulemaking and Other Pertinent Information:  None

e) Part(s) (Heading and Code Citation):  Illinois Loan Brokers Act of 1995; 14 Ill. Admin. Code 145

1) Rulemaking:

A) Description:  Amend and draft rules generally to conform regulations to legislative changes.


C) Scheduled Meeting/Hearing Dates:  None

D) Date the Agency Anticipates First Notice:  Unknown

E) Impact on Small Businesses, Small Municipalities or Not For Profit Corporations:  Unknown

F) Agency Contact Person for Information:

Tanya Solov, Director
Illinois Securities Department
Office of the Secretary of State
69 W. Washington Street, Suite 1220
Chicago IL  60602
312-793-3384  Fax:  312-7930-1202
tsolov@ilsos.net

G) Related Rulemaking and Other Pertinent Information:  None

f) Part(s) (Heading and Code Citation):  Procedures and Standards; 92 Ill. Admin. Code 1001.10, et seq.

1) Rulemaking:
A) **Description:** The Department is considering some modifications and clarifications to its hearing procedure (Subpart A of 92 IAC Part 1001), Safety Responsibility hearings (Subpart B), Informal Hearings (Subpart C), and to some substantive rules on hearings (Subpart D). Among others, the following amendments are under consideration.

- Require that a petition to contest an implied consent suspension be filed within a specified number of days after the effective date of the suspension (§1001.70). There are currently a couple of conflicting appellate court opinions which address this issue;

- Remove the rule which allows a petitioner to file a Motion to Correct a material Misstatement of Fact (§§1001.80 and 1001.110(g));

- Amending the rules of evidence to explicitly allow the admission of an arresting officers narrative investigative report at implied consent hearings conducted by the Department, even when the officer fails to appear in response to a subpoena issued by the Department (§1001.100(d));

- Shorten the period of time within which an out-of-state petitioner must provide the information required by the rules of the Secretary of State in order to obtain driving relief. The time frame currently in effect (90 days) has proven to be too long. (§1001.100(n)(6));

- The Department is considering sending notices of hearing and final orders entered after a hearing by electronic transmission; This practice would require the amendment of the rule on Orders (§1001.110(d)) – to add notification by electronic transmission;

- Add a provision to the rules on Safety Responsibility hearings (at 92 IAC §1001.220(j)), which will specify how people who were not parties to a hearing may obtain a copy of the record of a hearing. This procedure will be consistent with the Freedom of Information Act.

- In §1001.300(b)(4) of 92 IAC, clarify/specify that an information hearing cannot consider a petition for driving relief when the open
revocation was entered pursuant to the rules of the Secretary of State at 92 Ill. Adm. Code §1040.35;

- Amend §1001.300(c)(3) of 92 IAC to specify the offenses which preclude the

- Revising the definition of “alcohol” in §1001.410 to include the alcohol used in prescribed and over-the-counter medications. There is some evidence, currently being gathered by the BAIID Unit, that some BAIID permittees may be substituting medications for alcoholic beverages.

- Amend §1001.420(k) of IAC to make it consistent with a recent revision of the IVC (see P.A. 94-473);

- Remove the rule which requires a petitioner who has been issued a restricted driving permit to drive on the permit for 75% of its length before applying for reinstatement (§1001.430(i));

- Clarify the rule on when a petitioner may take a driver risk education course in a state other than Illinois (§1001.440(a)(1));

- Amend various subparagraphs in subsection (b) of §1001.440 to reflect the change in the name of the agency formerly known as the Department of Professional regulation to the Department of Financial and Professional Regulation.

- Clarify the rule on composition of updated evaluations by treatment providers. The question has arisen whether a treatment provider can compose an updated evaluation after the transfer of a petitioner’s treatment file. We may also expand upon the circumstances under which a transfer will be accepted (§1001.440(a)(6)(A));

- The Department's rule on Uniform Reports or original evaluations was recently amended to require that a chronological alcohol/drug use history be included or attached as part of the evaluation. We intend to extend this requirement to Investigative Evaluations (§1001.440(a)(4) and .440(a)(6)(D));
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

- Propose a definition of a "Treatment Needs Assessment" in §1001.410 of 92 IAC and, in §.440(b), clarify/codify the circumstances when a TNA is required to be provided by a treatment provider. A TNA is a statement from the treatment provider, which assesses a petitioner’s current need for treatment for alcohol/drug abuse.

- We may reconsider the rule which states that participation in internet AA meetings will not be accepted as a substitute for the attendance of such meetings in person (§1001.440(h));

- Somewhere in §1001.441, we must state a policy on who we will proves violations of the BAIID program which are revealed by monitor reports that are received after a BAIID permittee has been reinstated;

- Amend §1001.441(i)(6) of 92 IAC to provide that the BAIID Unit must ask for a letter of explanation before it can seek the cancellation of a BAIID permittee for tampering with his/her interlock device;

- Section 1001.443 of 92 IAC may undergo substantial revision if the federal law which mandates the use of an interlock device for 12 months on all vehicles owned by a multiple offender is changed. If the 12-month rule is not changed, then we will amend our rules to provide for the use of the interlock device for 365 days, rather than 12 months. This is due to the fact that some BAIID multiple offenders have removed the device during the twelfth month of their requirement, rather than serving the full 12 consecutive months. Second, subsection (b)(2) will be amended to state that the 12 months begins with the certification that an interlock device has been installed on the first vehicle listed by the offender;

- Clarify the circumstances under which (and what) sanctions are imposed pursuant to the BAIID multiple offender program in §1001.443(c) and (d);

- Remove the limitation on applying for a formal hearing once every four (4) months (§1001.450(a));
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

• Add a requirement that one who applies for a restricted driving permit pursuant to §11-501.8(e) of the IVC (after a "zero tolerance suspension), must submit a copy of the ZT sworn report to the informal hearing officer (§1001.670);

• Clarify when a ZT petitioner must submit an alcohol/drug use evaluation with his/her petition for a restricted driving permit. See §1001.670(a)(1).

B) Statutory Authority: 625 ILCS 5/2-104

C) Scheduled Meeting/Hearing Dates: None as yet

D) Date the Agency Anticipates First Notice: Spring 2006

E) Impact on Small Business, Small Municipalities or Not For Profit Corporations: We do not anticipate some impact on small businesses.

F) Agency Contact Person for Information:

Marc Christopher Loro
Legal Advisor
Administrative Hearings
Office of the Secretary of State
Room 200, Howlett Building
Springfield IL  62756
217-785-8245   Fax 217-782-2192
mloro@ilsos.net

G) Related Rulemaking and Other Pertinent Information: None

g) Part(s) (Heading and Code Citations): Business Corporation Act; 14 Ill. Admin. Code 150

1) Rulemaking:

A) Description: New Rule 150.735. Provides rules establishing standards for the acceptance of a signature in a form other than the proper handwriting of the person filing a document that requires his or her signature.
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

B) Statutory Authority: Implemented and authorized by Section 15(a) of the Secretary of State Act (15 ILCS 305/15(a))

C) Scheduled Meeting/Hearing Dates: Unknown

D) Date the Agency Anticipates First Notice: Unknown

E) Impact on Small Business, Small Municipalities or Not for Profit Corporation: Improved service.

F) Agency Contact Person for Information:

    Robert Durchholz
    Department of Business Services
    Room 330 Howlett Building
    Springfield, Illinois 62756
    Fax 217-782-1644
    rdurchholz@ilsos.net

G) Related Rulemaking and Other Pertinent Information: New Section 160.18 for Not For Profit Corporations.

h) Part(s) (Heading and Code Citations): General Not For Profit Corporations; 14 Ill. Admin. Code 160

1) Rulemaking:

   A) Description: New Rule 160.18. Provides rules establishing standards for the acceptance of a signature in a form other than the proper handwriting of the person filing a document that requires his or her signature.

   B) Statutory Authority: Implemented and authorized by Section 15(a) of the Secretary of State Act (15 ILCS 305/15(a))

   C) Scheduled Meeting/Hearing Dates: Unknown

   D) Date the Agency Anticipates First Notice: Unknown

   E) Impact on Small Business, Small Municipalities or Not for Profit Corporation: Improved service.
F) Agency Contact Person for Information:

Robert Durchholz  
Department of Business Services  
330 Howlett Building  
Springfield, Illinois 62756  
Fax 217-782-1644  
rdurchholz@ilsos.net


i) Part(s) (Heading and Code Citations): Limited Liability Company Act; 14 Ill. Admin. Code 178

1) Rulemaking:

A) Description: Amends 178.10. Establishes a definition of the term "electronic filing".

B) Statutory Authority: Implemented and authorized by Section 15 of the Secretary of State Act (15 ILCS 305/15) and section 50-20 of the Illinois Limited Liability Company act (805 ILCS 180/50-20)

C) Scheduled Meeting/Hearing Dates: Unknown

D) Date the Agency Anticipates First Notice: Unknown

E) Impact on Small Business, Small Municipalities or Not for Profit Corporation: Limited liability companies, most of which are small businesses, will have the convenience of being able to file some documents, such as the Annual Report, online. This ability will be an option for the businesses to pursue, not a requirement, as the Secretary of State will continue to file paper versions of all forms.

F) Agency Contact Person for Information:

Chuck Moles  
Department of Business Services
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

Room 351 Howlett Building
Springfield, Illinois  62756
Fax: 217-524-3390
cmoles@ilsos.net

G) Related Rulemaking and Other Pertinent Information: The Department of Business Services seeks to modernize its procedures and move toward offering on-line filing capabilities. Accordingly, the bulk of the proposals appearing for this agenda relate to these abilities, which also apply to corporations, Part 150, and transactions effected under Revised Article 9 of the Uniform Commercial Code, Park 180.

j) Part(s) (Heading and Code Citations): Limited Liability Company Act; 14 Ill. Admin. Code 178

1) Rulemaking:

A) Description: Amends 178.20. Allows the Secretary of State, at his or her discretion, to file documents submitted electronically while satisfying the document execution provisions.

B) Statutory Authority: Implemented and authorized by Section 15 of the Secretary of State Act (15 ILCS 305/15) and Section 50-20 of the Illinois Limited Liability Company act (805 ILCS 180/50-20)

C) Scheduled Meeting/Hearing Dates: Unknown

D) Date the Agency Anticipates First Notice: Unknown

E) Impact on Small Business, Small Municipalities or Not for Profit Corporation: Limited liability companies, most of which are small businesses, will have the convenience of being able to file some documents, such as the Annual Report, on line. This ability will be an option for the businesses to pursue, not a requirement, as the Secretary of State will continue to file paper versions of all forms.

F) Agency Contact Person for Information:

Chuck Moles
Department of Business Services
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

Room 351 Howlett Building
Springfield, Illinois  62756
Fax: 217-524-3390
cmoles@ilsos.net

G) Related Rulemaking and Other Pertinent Information: An identical provision is being proposed on behalf of corporations under Part 150. The Department of Business Services seeks to modernize its procedures and move toward offering on-line filing capabilities. Accordingly, the bulk of the proposals appearing for this agenda relate to these abilities, which also apply to corporations, Part 150, and transactions effected under Revised Article 9 of the Uniform Commercial Code, Park 180.

k) Part(s) (Heading and Code Citations): Limited Liability Company Act; 14 Ill. Admin. Code 178

1) Rulemaking:

A) Description: Amends 178.40. Allows the Secretary of State, at his or her discretion, to make information concerning limited liability companies available on line.

B) Statutory Authority: Implemented and authorized by Section 50-20 of the Illinois Limited Liability Company Act (805 ILCS 180/50-20)

C) Scheduled Meeting/Hearing Dates: Unknown

D) Date the Agency Anticipates First Notice: Unknown

E) Impact on Small Business, Small Municipalities or Not for Profit Corporation: Along with the general public, limited liability companies, most of which are small businesses, will have the convenience of being able to obtain information on line. This ability will be an option for the businesses to pursue, not a requirement, as the secretary of State will continue to provide information by telephone, in person, or through the mail.

F) Agency Contact Person for Information:

Chuck Moles
G) Related Rulemaking and Other Pertinent Information: The bulk of the proposals appearing for this agenda relate to the ability to file documents or obtain information online, which also apply to corporations, Part 150, and transactions effected under Revised Article 9 of the Uniform Commercial Code, Part 180.


1) Rulemaking:

A) Description: Amends 178.27. Adds electronic fund transfers and debit cards to the methods available for payment of fees in connection with filings effected with and services provided by the Secretary of State.

B) Statutory Authority: Implemented and authorized by Section 15 of the Secretary of State Act (15 ILCS 305/15) and Section 50/20 of the Illinois Limited Liability Company Act (805 ILCS 180/50-20).

C) Scheduled Meeting/Hearing Dates: Unknown

D) Date the Agency Anticipates First Notice: Unknown

E) Impact on Small Business, Small Municipalities or Not for Profit Corporation: Along with the general public, limited liability companies, most of which are small businesses, will have the convenience of being able to pay for the filing of documents or obtaining of services through electronic fund transfers or debit cards, in addition to the various existing forms of payment.

F) Agency Contact Person for Information:

Chuck Moles
Department of Business Services
SECURITY OF STATE

JANUARY 2006 REGULATORY AGENDA

Room 351 Howlett Building
Springfield, Illinois  62756
Fax:  217-524-3390
cmoles@ilsos.net

G)  Related Rulemaking and Other Pertinent Information:  A similar provision concerning electronic funds transfers already exists for Article 9 of the Uniform Commercial Code at 14 Ill. Admin. Code 180.13(b)(3) and one is being proposed for debit cards at new 14 Ill. Admin. Code 180.13(b)(5).

m)  Part(s) (Heading and Code Citations): Limited Liability Company Act; 14 Ill. Admin. Code 178

1)  Rulemaking:

A)  Description:  Amends 178.65.  Allows the Secretary of State to stay current with new practices and technologies as electronic capabilities continue to expand.

B)  Statutory Authority:  Implemented and authorized by Section 15 of the Secretary of State Act (15 ILCS 305/15) and Section 50/20 of the Illinois Limited Liability Company Act (805 ILCS 180/50-20)

C)  Scheduled Meeting/Hearing Dates:  Unknown

D)  Date the Agency Anticipates First Notice:  Unknown

E)  Impact on Small Business, Small Municipalities or Not for Profit Corporation:  Limited liability companies, most of which are small businesses, will benefit from technological advancements and opportunities initiated by or offered through the Office of the Secretary of State.

F)  Agency Contact Person for Information:

Chuck Moles
Department of Business Services
Room 351 Howlett Building
Springfield, Illinois  62756
Fax:  217-524-3390
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

cmoles@ilsos.net

G) Related Rulemaking and Other Pertinent Information: A similar provision is being proposed on behalf of Article 9 of the Uniform Commercial Code at 14 Ill. Admin. Code 180.14(f).

n) Part(s) (Heading and Code Citations): Limited Liability Company Act; 14 Ill. Admin. Code 180

1) Rulemaking:

A) Description:

Amends 180.10. Adds a definition for online services.

Amends 180.11(a)(1), (2) and (3). Specifies that date and time of receipt are stamped on the UCC document 178.65.

Amends 180.11(a)(4). Specifies availability of UCC online services and file time for UCC records tendered online.

Amends 180.11(a)(5). Specifies UCC Division office hours for both paper and on line filings.

Amends 180.11(a)(6). Gives UCC Division location.

Amends 180.12(e). Provides guidelines when multiple types of amendments are being filed.

Amends 180.13(a)(1) Adds fee for online filing.

Amends 180.13(b)(5). Provides guidelines for payment of UCC filing fees by debit card.


Amends 180.16(c)(2). Changes maximum length of organization name field.
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

Amends 180.18(a)(4). Provides clarification for doing a UCC filing and search to reflect the filing.


C) Scheduled Meeting/Hearing Dates: Unknown

D) Date the Agency Anticipates First Notice: Unknown

E) Impact on Small Business, Small Municipalities or Not for Profit Corporation: Limited liability companies, most of which are small businesses, will benefit from technological advancements and opportunities initiated by or offered through the Office of the Secretary of State.

F) Agency Contact Person for Information:

Dennis L. Hankins, Administrator
Department of Business Services
Uniform Commercial Code Division
501 South Second Street
Room 350 Howlett Building
Springfield, Illinois 62756
Fax: 217/ 557-4430
dhankins@ilsos.net

G) Related Rulemaking and Other Pertinent Information: None

o) Part(s) (Heading and Code Citations): Illinois State Library, Library Services Division; 23 Ill. Admin. Code 3010

1) Rulemaking:

A) Description: The application for a State library courtesy card will be amended to exclude a Social Security number, and the cost of providing copies of digital images and maps will be amended in the rulemaking.
ILLINOIS REGISTER

SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

B) Statutory Authority: Implementing Section 21 and authorized by Section 2 of the State Library Act [15 ILCS 320/2 and 21]

C) Scheduled Meeting/Hearing Dates: None

D) Date Agency Anticipates First Notice: February 2006

E) Impact on Small Businesses, Small Municipalities or Not for Profit Corporations: None

F) Agency Contact Person for Information:

   Illinois State Library
   Joseph Natale
   Rules Coordinator
   Gwendolyn Brooks Building
   300 South Second Street
   Springfield IL 62701-1796
   217-558-4185 Fax 217-557-2619
   jnatale@ilsos.net

G) Related Rulemakings and Other Pertinent Information: None

p) Part(s) (Heading and Code Citations): Illinois State Library; Acquisition Division, Illinois Documents Section; 23 Ill. Admin. Code 3020

1) Rulemaking:

A) Description: Section 23 Ill. Admin. Code 3020.110 will be amended to clarify the method for State agencies to transmit electronic publications to the Illinois State Library for public access through the Internet.

B) Statutory Authority: Implementing Section 21 and authorized by Section 2 of the State Library Act [15 ILCS 320/2 and 21]

C) Scheduled Meeting/Hearing Dates: None

D) Date Agency Anticipates First Notice: January 2006
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

E) Impact on Small Businesses, Small Municipalities or Not for Profit Corporations: None

F) Agency Contact Person for Information:

Illinois State Library
Joseph Natale
Rules Coordinator
Gwendolyn Brooks Building
300 South Second Street
Springfield IL 62701-1796
217/558-4185 Fax 217/557-2619
jnatale@ilsos.net

G) Related Rulemakings and Other Pertinent Information: None

q) Part(s) (Heading and Code Citations): The Illinois State Library System Act; 23 Ill Admin. Code 3030

1) Rulemaking:

A) Description: This Part will be reviewed in order to renumber and reorganize its content to facilitate use.

B) Statutory Authority: Implementing and authorized by the Illinois Library system act [75 ILCS 10]

C) Scheduled Meeting/Hearing Dates: To be announced

D) Date Agency Anticipates First Notice: March 2006

E) Impact on Small Businesses, Small Municipalities or Not for Profit Corporations: None

F) Agency Contact Person for Information:

Illinois State Library
Joseph Natale
Rules Coordinator
Gwendolyn Brooks Building
r) Part(s) (Heading and Code Citations): Literacy Grant Progress; 23 Ill. Admin. Code 3040

1) Rulemaking:

A) Description: Clarify role of the Literacy Advisory Board and granting and fiscal procedures.

B) Statutory Authority: Implementing and authorized by the State Library Act [15 ILCS 320] and the Illinois Literacy Act [15 ILCS 322]

C) Scheduled Meeting/Hearing Dates: To be announced

D) Date Agency Anticipates First Notice: March 2006

E) Impact on Small Businesses, Small Municipalities or Not for Profit Corporations: None

F) Agency Contact Person for Information:

   Illinois State Library
   Joseph Natale
   Rules Coordinator
   Gwendolyn Brooks Building
   300 South Second Street
   Springfield IL  62701-1796
   217/558-4185  Fax 217/557-2619
   jnatale@ilsos.net

G) Related Rulemakings and Other Pertinent Information: None

s) Part(s) (Heading and Code Citations): Public Library Construction Grants; 23 Ill. Admin. Code 3060

1) Rulemaking:
SECRETARY OF STATE

JANUARY 2006 REGULATORY AGENDA

A) Description: Establish the funding priorities and criteria for FY 2007 construction and revise the definition of the “Library Building Consultant.”

B) Statutory Authority: Implementing Section 3 of the Capital Development Bond Act of 1972 [30 ILCS 420/3] and authorized by Sections 3 and 8 of the Illinois Library System Act [75 ILCS 10/3 and 8]

C) Schedule Meeting/Hearing Date: None

D) Date Agency Anticipates First Notice: June 2006

E) Impact on Small Businesses, Small Municipalities or Not for Profit Corporations: None

F) Agency Contact Person for Information:

   Illinois State Library
   Joseph Natale
   Rules Coordinator
   Gwendolyn Brooks Building
   300 South Second Street
   Springfield IL  62701-1796
   217/558-4185  Fax 217/557-2619
   jnatale@ilsos.net

G) Related Rulemakings and Other Pertinent Information: None
a) Part(s) (Heading and Code Citation): Gainful Employment; 80 Ill. Adm. Code 1540.80(e)

1) Rulemaking:

A) Description: The gainful employment limitation is linked to the Social Security Administration’s Substantial Gainful Activity (SGA) dollar amount. If the Social Security Administration (SSA) is going to change the SGA dollar amount, they typically do so in January. This notice is posted in the event that if the SSA changes the SGA, the State Employees’ Retirement System can, in turn, change the gainful employment amount in this rule.

B) Statutory Authority: 40 ILCS 5/14-101

C) Scheduled meeting/hearing dates: N/A

D) Date agency anticipates First Notice: If the SSA raises the Substantial Gainful Activity dollar amount, SERS will follow suit.

E) Affect on small businesses, small municipalities or not for profit corporations: None

F) Agency contact person for information:

Pat Cummings
2101 S. Veterans Parkway
P.O. Box 19255
Springfield IL 62794-9276
217/785-7260

G) Related rulemakings and other pertinent information: None

b) Part(s) (Heading and Code Citation): Qualified Illinois Domestic Relations Orders (QILDRO); 80 Ill. Adm. Code 1540.350(a-m)

1) Rulemaking:
STATE EMPLOYEES’ RETIREMENT SYSTEM OF ILLINOIS

JANUARY 2006 REGULATORY AGENDA

A) Description: P. A. 94-0657 became law on July 1, 2005, and will take effect on July 1, 2006. It is anticipated that a major rule change will occur in order to implement this new legislation.

B) Statutory Authority: 40 ILCS 5/14-101

C) Scheduled meeting/hearing dates: N/A

D) Date agency anticipates First Notice: February 1, 2006

E) Affect on small businesses, small municipalities or not-for-profit corporations: None

F) Agency contact person for information:

    Pat Cummings
    2101 S. Veterans Parkway
    P.O. Box 19255
    Springfield IL  62794-9276
    217/785-7260

G) Related rulemakings and other pertinent information: None
STATE UNIVERSITIES RETIREMENT SYSTEM
OF THE STATE OF ILLINOIS

JANUARY 2006 REGULATORY AGENDA

a) Part (Heading and Code Citation): Dependency of Beneficiaries; 80 Ill. Adm. Code 1600.20

1) Rulemaking:

   A) Description: Modification of current dependency rule to clarify elements of dependency and the burden of proof.


   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. No public hearing is anticipated.

   D) Date agency anticipates First Notice: March 2006

   E) Effect on small businesses, small municipalities or not for profit corporations: None

   F) Agency contact person for information:

      Albert J. Lee, Assistant General Counsel
      State Universities Retirement System
      1901 Fox Drive
      Champaign IL 61820
      217/378-7516

   G) Related rulemakings and other pertinent information: None

b) Part (Heading and Code Citation): Freedom of Information Act; 80 Ill. Adm. Code 1600.100

1) Rulemaking:

   A) Description: A revision to the current rule further defining "public records" and describing "personal information" under paragraph f (2)(A).
STATE UNIVERSITIES RETIREMENT SYSTEM OF THE STATE OF ILLINOIS
JANUARY 2006 REGULATORY AGENDA


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. No public hearing is anticipated.

D) Date agency anticipates First Notice: March 2006

E) Effect on small businesses, small municipalities or not for profit corporations: None

F) Agency contact person for information:

   Albert J. Lee, Assistant General Counsel
   State Universities Retirement System
   1901 Fox Drive
   Champaign IL 61820
   217/378-7516

G) Related rulemakings and other pertinent information: None

c) Part (Heading and Code Citation): Procurement; 80 Ill. Adm. Code 1600.130

   1) Rulemaking:

      A) Description: A revision will be made to the current rule regarding investment management.


      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. No public hearing is anticipated.

      D) Date agency anticipates First Notice: March 2006
E) Effect on small businesses, small municipalities or not for profit corporations: None

F) Agency contact person for information:

Albert J. Lee, Assistant General Counsel
State Universities Retirement System
1901 Fox Drive
Champaign IL 61820
217/378-7516

G) Related rulemakings and other pertinent information: None

d) Part (Heading and Code Citation): Making Preliminary Estimated Payments; 80 Ill. Adm. Code 1600.140

1) Rulemaking:

A) Description: Revise the current rule on Making Preliminary Estimated Payments to include procedures for holding payments when the member has not responded to informational requests.


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. No public hearing is anticipated.

D) Date agency anticipates First Notice: March 2006

E) Effect on small businesses, small municipalities or not for profit corporations: None

F) Agency contact person for information:

Albert J. Lee, Assistant General Counsel
State Universities Retirement System
1901 Fox Drive
STATE UNIVERSITIES RETIREMENT SYSTEM
OF THE STATE OF ILLINOIS

JANUARY 2006 REGULATORY AGENDA

Champaign IL  61820
217/378-7516

G) Related rulemakings and other pertinent information: None

e) Part (Heading and Code Citation): Document Retention; 80 Ill. Adm. Code 1600.15

1) Rulemaking:

A) Description: A Section to set forth retention periods for the various categories of documents used by the System in business operations.


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. No public hearing is anticipated.

D) Date agency anticipates First Notice: March 2006

E) Effect on small businesses, small municipalities or not for profit corporations: None

F) Agency contact person for information:

Albert J. Lee, Assistant General Counsel
State Universities Retirement System
1901 Fox Drive
Champaign IL  61820
217/378-7516

G) Related rulemakings and other pertinent information: None

f) Part (Heading and Code Citation): Negative Payrolls; 80 Ill. Adm. Code 1600.15

1) Rulemaking: No docket number presently assigned.
STATE UNIVERSITIES RETIREMENT SYSTEM
OF THE STATE OF ILLINOIS

JANUARY 2006 REGULATORY AGENDA

A) **Description:** A Section to set forth in order to formalize the procedures for accepting or rejecting negative payrolls from employers.

B) **Statutory Authority:** Article 15 of the Illinois Pension Code, 40 ILCS 5/15-177.

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*. No public hearing is anticipated.

D) **Date agency anticipates First Notice:** March 2006

E) **Effect on small businesses, small municipalities or not for profit corporations:** None

F) **Agency contact person for information:**

   Albert J. Lee, Assistant General Counsel
   State Universities Retirement System
   1901 Fox Drive
   Champaign IL  61820
   217/378-7516

G) **Related rulemakings and other pertinent information:** None
ILLINOIS WORKERS’ COMPENSATION COMMISSION

JANUARY 2006 REGULATORY AGENDA


1) Rulemaking:

   A) Description: The rulemaking amends the Commission's arbitration and review procedures, including procedures relating to expedited hearings under Section 19(b) of the Workers' Compensation Act.

   B) Statutory Authority: 820 ILCS 305/16 and 19

   C) Scheduled meeting/hearing dates: No dates have been set.

   D) Date agency anticipates First Notice: No date has been set.

   E) Affect on small businesses, small municipalities or not for profit corporations: None

   F) Agency contact person for information:

      Kathryn A. Kelley, Counsel
      100 West Randolph, Suite 8-272
      Chicago IL  60601
      312/814-6559

   G) Related rulemakings and other pertinent information: None

b) Part (Heading and Code Citation): Arbitration; 50 Ill. Adm. Code 7030

1) Rulemaking:

   A) Description: The rulemaking amends the Commission's arbitration procedures, including procedures relating to requesting arbitration decisions which include findings of fact and conclusions of law under Section 19(b) of the Workers' Compensation Act.

   B) Statutory Authority: 820 ILCS 305/16 and 19

   C) Scheduled meeting/hearing dates: No dates have been set.
ILLINOIS WORKERS’ COMPENSATION COMMISSION

JANUARY 2006 REGULATORY AGENDA

D) Date agency anticipates First Notice: No date has been set.

E) Affect on small businesses, small municipalities or not for profit corporations: None

F) Agency contact person for information:

   Kathryn A. Kelley, Counsel
   100 West Randolph, Suite 8-272
   Chicago IL  60601
   312/814-6559

G) Related rulemakings and other pertinent information: None

c) Part (Heading and Code Citation): Miscellaneous; 50 Ill. Adm. Code 7110

1) Rulemaking:

   A) Description: The rulemaking amends the Commission's procedures to provide for a workers' compensation medical fee schedule in accordance with Section 8.2 of the Workers' Compensation Act and requirements for certification of vocational rehabilitation counselors in accordance with Section 8(a) of the Act.

   B) Statutory Authority: 820 ILCS 305/8(a), 8.2, 16 and 19

   C) Scheduled meeting/hearing dates: No dates have been set.

   D) Date agency anticipates First Notice: January 2006

   E) Affect on small businesses, small municipalities or not for profit corporations: None

   F) Agency contact person for information:

      Kathryn A. Kelley, Counsel
      100 West Randolph, Suite 8-272
      Chicago IL  60601
      312/814-6559
ILLINOIS WORKERS’ COMPENSATION COMMISSION

JANUARY 2006 REGULATORY AGENDA

G) Related rulemakings and other pertinent information: None

d) Part (Heading and Code Citation): Insurance Regulations; 50 Ill. Adm. Code 7100

1) Rulemaking:

A) Description: The rulemaking amends the Commission's insurance procedures, including procedures relating to insurance compliance under Section 4 of the Workers' Compensation Act.

B) Statutory Authority: 820 ILCS 305/4, 16 and 19

C) Scheduled meeting/hearing dates: No dates have been set.

D) Date agency anticipates First Notice: No date has been set.

E) Affect on small businesses, small municipalities or not for profit corporations: None

F) Agency contact person for information:

    Kathryn A. Kelley, Counsel
    100 West Randolph, Suite 8-272
    Chicago IL  60601
    312/814-6559

G) Related rulemakings and other pertinent information: None
NOTICES: The scheduled date and time for the JCAR meeting are subject to change. Due to Register submittal deadlines, the Agenda below may be incomplete. Other items not contained in this published Agenda are likely to be considered by the Committee at the meeting and items from the list can be postponed to future meetings.

If members of the public wish to express their views with respect to a rulemaking, they should submit written comments to the Office of the Joint Committee on Administrative Rules at the following address:

Joint Committee on Administrative Rules
700 Stratton Office Building
Springfield, Illinois 62706

Email: jcar@legis.state.il.us
Phone: 217/785-2254

RULEMAKINGS CURRENTLY BEFORE JCAR

Agriculture

1. Fairs Operating Under the Agricultural Fair Act (8 Ill. Adm. Code 260)
   -First Notice Published: 29 Ill. Reg. 14413 – 9/30/05
   -Expiration of Second Notice: 1/18/06

Attorney General

   -First Notice Published: 29 Ill. Reg. 13937 – 9/16/05
   -Expiration of Second Notice: 2/2/06

Central Management Services

   -First Notice Published: 29 Ill. Reg. 14420 – 9/30/05
Children and Family Services

4. Services Delivered by the Department of Children and Family Services (89 Ill. Adm. Code 302)
   -First Notice Published: 29 Ill. Reg. 5835 – 4/29/05
   -Expiration of Second Notice: 1/29/06

   -First Notice Published: 29 Ill. Reg. 14452 – 9/30/05
   -Expiration of Second Notice: 2/3/06

   -First Notice Published: 29 Ill. Reg. 14601 – 10/7/05
   -Expiration of Second Notice: 2/3/06

7. The "Grow Your Own" Teacher Education Initiative (23 Ill. Adm. Code 60)
   -First Notice Published: 29 Ill. Reg. 15367 – 10/14/05
   -Expiration of Second Notice: 2/3/06

8. Disadvantaged Students Funds Plan – Districts Between 1,000 and 50,000 ADA (Repealer) (23 Ill. Adm. Code 201)
   -First Notice Published: 29 Ill. Reg. 14614 – 10/7/05
   -Expiration of Second Notice: 2/1/06

9. Disadvantaged Students Funds Plan – Districts Over 50,000 ADA (Repealer) (23 Ill. Adm. Code 202)
   -First Notice Published: 29 Ill. Reg. 14620 – 10/7/05
   -Expiration of Second Notice: 2/1/06

10. Disadvantaged Students Funds Plan (23 Ill. Adm. Code 203)
    -First Notice Published: 29 Ill. Reg. 14637 – 10/7/05
    -Expiration of Second Notice: 2/1/06

Employment Security

11. Disqualifying Income and Reduced Benefits (56 Ill. Adm. Code 2920)
    -First Notice Published: 29 Ill. Reg. 15764 – 10/21/05
JOINT COMMITTEE ON ADMINISTRATIVE RULES
JANUARY AGENDA

-Expiration of Second Notice: 1/19/06

Environmental Protection Agency

   -First Notice Published: 29 Ill. Reg. 16133 – 10/28/05
   -Expiration of Second Notice: 2/1/06

Financial and Professional Regulation

13. Predatory Lending Database (38 Ill. Adm. Code 346)
   -First Notice Published: 29 Ill. Reg. 15772 – 10/21/05
   -Expiration of Second Notice: 2/3/06

   -First Notice Published: 29 Ill. Reg. 5808 – 4/29/05
   -Expiration of Second Notice: 1/29/06

   -First Notice Published: 29 Ill. Reg. 3057 – 3/4/05
   -Expiration of Second Notice: 2/9/06

   -First Notice Published: 29 Ill. Reg. 13949 – 9/16/05
   -Expiration of Second Notice: 2/9/06

Labor

   -First Notice Published: 29 Ill. Reg. 15427 – 10/14/05
   -Expiration of Second Notice: 1/27/06

   -First Notice Published: 29 Ill. Reg. 15455 – 10/14/05
   -Expiration of Second Notice: 2/1/06

Pollution Control Board

   -First Notice Published: 29 Ill. Reg. 5873 – 4/29/05
   -Expiration of Second Notice: 2/9/06
   -First Notice Published: 29 Ill. Reg. 3538 – 3/11/05
   -Expiration of Second Notice: 1/22/06

   -First Notice Published: 29 Ill. Reg. 3705 – 3/11/05
   -Expiration of Second Notice: 1/22/06

Property Tax Appeal Board

   -First Notice Published: 29 Ill. Reg. 15503 – 10/14/05
   -Expiration of Second Notice: 2/3/06

Public Health

23. Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300)
   -First Notice Published: 29 Ill. Reg. 13346 – 9/2/05
   -Expiration of Second Notice: 1/22/06

   -First Notice Published: 29 Ill. Reg. 13389 – 9/2/05
   -Expiration of Second Notice: 1/22/06

   -First Notice Published: 29 Ill. Reg. 13429 – 9/2/05
   -Expiration of Second Notice: 1/22/06

   -First Notice Published: 29 Ill. Reg. 13460 – 9/2/05
   -Expiration of Second Notice: 1/22/06

27. Long-Term Care for Under Age 22 Facilities Code (77 Ill. Adm. Code 390)
   -First Notice Published: 29 Ill. Reg. 13501 – 9/2/05
   -Expiration of Second Notice: 1/22/06
EMERGENCY RULEMAKINGS

Central Management Services

   -Notice Published: 29 Ill. Reg. 20540 – 12/16/05

   -Notice Published: 29 Ill. Reg. 20554 – 12/16/05

   -Notice Published: 29 Ill. Reg. 20050 – 12/9/05

Commerce and Economic Opportunity

   -Notice Published: 29 Ill. Reg. 20665 – 12/27/05

Financial and Professional Regulation

32. Predatory Lending Database (38 Ill. Adm. Code 346) (Emergency)
   -Notice Published: 30 Ill. Reg. 208 – 1/6/06

Gaming Board

   -Notice Published: 29 Ill. Reg. 20095 – 12/9/05

Higher Education

34. Health Services Education Grants Act (23 Ill. Adm. Code 1020) (Emergency)
   -Notice Published: 29 Ill. Reg. 20684 – 12/27/05

PEREMPTORY RULEMAKINGS

Agriculture

   -Notice Published: 29 Ill. Reg. 20580 – 12/16/05
   - Notice Published: 29 Ill. Reg. 21058 – 12/30/05

Central Management Services

37. Pay Plan (80 Ill. Adm. Code 310)
   - Notice Published: 29 Ill. Reg. 20693 – 12/27/05 (Peremptory)

Children and Family Services

38. Reports of Child Abuse and Neglect (89 Ill. Adm. Code 300) (Peremptory)
   - Notice Published: 29 Ill. Reg. 21065 – 12/30/05

   - Notice Published: 29 Ill. Reg. 21091 – 12/30/05

AGENCY RESPONSES

Central Management Services


42. Pay Plan (80 Ill. Adm. Code 310; 29 Ill. Reg. 14098)

43. Financial Incentive Opt Out of the State Employees Group Health Plan for Non-Medicare
    State Employees Retirement System Annuitants (80 Ill. Adm. Code 2106; 29 Ill. Reg. 15976) (Emergency)

Education

44. Public Schools Evaluation, Recognition and Supervision (23 Ill. Adm. Code 1; 29 Ill. Reg. 9574)

Employment Security


Human Services
46. Child Care (89 Ill. Adm. Code 50; 28 Ill. Reg. 14737)
The following second notice was received by the Joint Committee on Administrative Rules during the period of December 27, 2005 through January 3, 2006 and has been scheduled for review by the Committee at its February 14, 2006 meeting in Springfield. 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.

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**ILLINOIS ADMINISTRATIVE CODE**

**Issue Index - With Effective Dates**

Rules acted upon in Volume 30, Issue 2 are listed in the Issues Index by Title number, Part number, Volume and Issue. Inquires about the Issue Index may be directed to the Administrative Code Division at (217) 782-7017/18.

**PROPOSED RULES**

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**ADOPTED RULES**

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**REGULATORY AGENDA**

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