

2003

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REGISTER

RULES
OF GOVERNMENTAL
AGENCIES



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Editor’s Note 1: The Cumulative Index and Sections Affected Index will be printed on a quarterly basis. The printing schedule for the quarterly and annual indexes are (End of March, June, Sept, Dec) as follows:

Issue 15 - April 11, 2003: Data through	March 31, 2003 (1 st Quarter)
Issue 28 - July 11, 2003: Data through	June 30, 2003 (2nd Quarter)
Issue 41 - October 10, 2003: Data through	September 29, 2003 (3rd Quarter)
Issue 2 - January 9, 2004: Data through	December 29, 2003 (Annual)

Editor’s Note 2: Submit all rulemaking documentation to the following address:

Secretary of State
Department of Index
Administrative Code Division
111 East Monroe Street
Springfield, Illinois 62756

COMPTROLLER

NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Voluntary Deductions from Wages, Salary, or Annuities
- 2) Code Citation: 80 Ill. Adm. Code 2500
- 3) Section Numbers: Proposed Action:
2500.51 Amend
- 4) Statutory Authority: Authorized and implementing by Section 10 of the State Salary and Annuity Withholding Act [5 ILCS 365/10] and Section 5 of the Voluntary Payroll Deductions Act of 1983 [5 ILCS 340/5].
- 5) Complete Description of the Subjects and Issues Involved: The proposed amendment is necessary to implement provisions of the Voluntary Payroll Deductions Act of 1983 as amended by P.A. 92-634, effective July 11, 2002. The proposed amendment reflects the need for individuals authorizing withholding for an organization to provide the last four digits of their social security number, rather than their entire social security number as currently required.
- 6) Will this rulemaking replace any emergency rulemaking 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 rulemakings pending on this Part? No.
- 10) Statement of Statewide Policy Objectives: The rulemaking does not create or expand a state mandate.
- 11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may submit written comments within 45 days of the date of publication to:

Shirley M. Soria
Division of Legal Counsel
Office of the Comptroller
201 State Capitol

COMPTROLLER

NOTICE OF PROPOSED AMENDMENT

Springfield, Illinois 62706
217/782-6000

- 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: This rulemaking was not summarized in a Regulatory Agenda because amendment of the rule was not contemplated at the time the most recent Regulatory Agenda was due.

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

COMPTROLLER

NOTICE OF PROPOSED AMENDMENT

TITLE 80: PUBLIC EMPLOYEES AND OFFICIALS

SUBTITLE F: PAYROLL DEDUCTIONS
CHAPTER I: COMPTROLLER

PART 2500

VOLUNTARY DEDUCTIONS FROM WAGES, SALARY OR ANNUITIES

Section

2500.10	Scope
2500.20	Authorization to Withhold
2500.30	Deduction Code Numbers
2500.40	Processing by State Agencies
2500.50	Special Provisions for United States Savings Bonds
2500.51	Special Provisions for Withholding Pursuant to the Voluntary Payroll Deductions Act of 1983
2500.60	Insufficient Wages or Annuity
2500.70	Precedence of Tax Levies

AUTHORITY: Implementing and authorized by Section 10 of the State Salary and Annuity Withholding Act [5 ILCS 365/10] and Section 5 of the Voluntary Payroll Deductions Act of 1983 [5 ILCS 340/5].

SOURCE: Adopted at 8 Ill. Reg. 1, effective January 6, 1984; amended at 8 Ill. Reg. 5170, effective April 6, 1984; amended at 26 Ill. Reg. 2656, effective February 22, 2002; amended at 27Ill. Reg. _____, effective _____.

2500.51 Special Provisions for Withholding Pursuant to the Voluntary Payroll Deductions Act of 1983

- a) A petitioning organization desiring to be designated as a "qualified organization" under the Voluntary Payroll Deductions Act of 1983 (the "Act") must submit written designations from at least 4,000 State employees and/or annuitants indicating that each employee or annuitant intends to authorize withholding for payment to that organization.
- b) Petitioning organizations shall submit proposed forms for the written designations to the Comptroller for approval. The Comptroller will approve the forms where the information set forth in this subsection (b) is included on such forms. At a

COMPTROLLER

NOTICE OF PROPOSED AMENDMENT

minimum, petitioning organizations shall include on the written designation forms the following:

- 1) Information identifying the petitioning organization;
 - 2) The employee's or annuitant's name (dated signature);
 - 3) The State Agency in which the employee is currently employed, if applicable;
 - 4) The [last four digits of the](#) employee's or annuitant's Social Security Number;
 - 5) A statement in prominent type "This is not a payroll deduction authorization.";
 - 6) A statement of the percentage of the organization's total collected receipts from employees' payroll and/or annuitants' deductions that are distributed to the benefiting agencies and the percentage of the organization's total collected receipts from employees' payroll and/or annuitants' deductions that are expended for fund-raising and overhead costs.
- c) No fewer than 4,000 employee and/or annuitant designations shall be submitted to the Comptroller by the petitioning organization at one time, in either of the following formats:
- 1) In a "petition" format with the information established in subsection (b) above prominently typed at the top of the page with spaces for up to 100 signatures.
 - 2) In a "card" format, with the information established in subsection (b) above typed on each card with a space for signature for only one employee or annuitant. The cards shall not exceed 8 1/2 by 11 inches and must be batched in groups of 100.
- d) Entities desiring designation as a qualified organization must show entitlement by making the certifications identified in Section 3(b)(2)-(10) of the Act. The certifications shall be transmitted along with the 4,000 written designations from employees and/or annuitants to the Comptroller at his offices at 325 West Adams

COMPTROLLER

NOTICE OF PROPOSED AMENDMENT

Street, Springfield, Illinois 62706 Attention: Payroll Department, in letter form signed by the chief executive officer (or his equivalent) of the requesting organization.

- e) By February 1 of each year, the Comptroller will notify by letter each qualified organization for which the Comptroller's records indicated that fewer than 500 employees and/or annuitants have authorized withholding on behalf of that organization. The notification shall give the qualified organization until March 1 to provide the Comptroller with documentation that the 500 deduction requirement has been met. If the qualified organization does not submit evidence that 500 employees and/or annuitants have authorized withholding on behalf of the organization within 30 calendar days after the date of the Comptroller's notification letter, the Comptroller will discontinue withholding for that organization. Evidence of withholding authorization by employees or annuitants may consist of signed payroll or annuity deduction authorization forms that include withholdings on behalf of such organizations or information submitted to the Comptroller by a university or retirement system that documents the number of State and university employees and annuitants who have authorized withholding on behalf of the organization during the prior calendar year. The Comptroller shall, by March 15 of each year, submit to the Governor or his or her designee, or such other agency as may be determined by the Governor, a list of all organizations that have met the 500 payroll deduction requirement.
- f) An employee or annuitant may authorize the withholding of a portion of his salary, wages, or annuity for contribution to a maximum number of four organizations described in Section 3 (b) and (c) of the Act [5 ILCS 340/4 and 4.5]. Once a State agency has received four currently effective deduction authorization forms from an employee or an annuitant for withholding on behalf of the organizations described in Section 3 (b) and (c) of the Act, the State agency shall accept no further deduction authorization forms for organizations described in Section 3 (b) and (c) of the Act from that employee or annuitant, unless a previously effective deduction authorization is terminated by the employee or annuitant (or by the expiration of the stated term of the prior authorization).
- g) As used in this Section, "employee" means any regular officer or employee who receives salary or wages for personal services rendered to the State of Illinois, including an individual hired as an employee by contract with that individual. [5 ILCS 340/3(a)]

COMPTROLLER

NOTICE OF PROPOSED AMENDMENT

- h) As used in this Section, "annuitant" means a person receiving an annuity or disability benefit under Article 2, 14, 15, 16 or 18 of the Illinois Pension Code [40 ILCS 5]. [5 ILCS 340/3(f)]

(Source: Amended at 27 Ill. Reg. _____, effective _____.)

STATE BOARD OF EDUCATION

NOTICE OF PROPOSED RULES

- 1) Heading of the Part: Alternative Learning Opportunities Program
- 2) Code Citation: 23 Ill. Adm. Code 240
- 3) Section Numbers: Proposed Action:
240.90 Amendment
- 4) Statutory Authority: 105 ILCS 5/Art. 13B
- 5) A Complete Description of the Subjects and Issues Involved: Section 13B-50.15 of the School Code [105 ILCS 5/13B-50.15] provides that regional offices of education that operate approved Alternative Learning Opportunities Programs (ALOPs) on behalf of school districts that established such programs “are entitled to receive general State aid at the foundation level of support.” The law, however, does not explicitly state whether these regional offices can submit a claim directly to the State Board of Education to receive General State Aid (GSA) or receive it from the school district or districts that contracted with the regional office to operate the ALOP.

The proposed amendments provide that regional offices of education may directly submit GSA claims to the State Board, provided that there is a cooperative agreement between the regional office and school district(s) that are establishing the program. This provision to allow for submission of the claim by the regional office will not apply to other entities, such as intermediate service centers, community colleges, health and human services agencies, and other public and private, not-for-profit agencies, that may be under contract with a school district to operate an ALOP.

Since students may enter an ALOP in the middle of a school year, the proposed amendments further provide that GSA can be claimed only for the time period in which those students are enrolled in the program. A similar provision is proposed for school districts.

- 6) Will these proposed rules replace an emergency rule currently in effect? No
- 7) Does this rulemaking contain an automatic repeal date? No
- 8) Do these proposed rules contain incorporations by reference? No
- 9) Are there any other proposed amendments pending on this Part? No

STATE BOARD OF EDUCATION

NOTICE OF PROPOSED RULES

10) Statement of Statewide Policy Objectives: This rulemaking will not create or enlarge a state mandate.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Written comments may be submitted within 45 days of the publication of this notice to:

Sally Vogl
Agency Rules Coordinator
Illinois State Board of Education
100 North First Street, S-284
Springfield, Illinois 62777-0001
(217) 782-3950

Comments may also be submitted electronically, addressed to:

rules@isbe.net

12) Initial Regulatory Flexibility Analysis:

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

B) Reporting, bookkeeping or other procedures required for compliance: Regional offices of education will be required to follow standard procedures established for the submission of claims for General State Aid.

C) Types of professional skills necessary for compliance: Not applicable

13) Regulatory Agenda on which this rulemaking was summarized: January 2003

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

STATE BOARD OF EDUCATION

NOTICE OF PROPOSED RULES

TITLE 23: EDUCATION AND CULTURAL RESOURCES

SUBTITLE A: EDUCATION

CHAPTER I: STATE BOARD OF EDUCATION

SUBCHAPTER f: INSTRUCTION FOR SPECIFIC STUDENT POPULATIONS

PART 240

ALTERNATIVE LEARNING OPPORTUNITIES PROGRAM

SUBPART A: PROGRAM APPROVAL

Section

240.10	Purpose
240.20	Requirements for Student Participation
240.25	Enrollment of Students with Individualized Education Programs
240.30	Program Requirements
240.40	Student Success Plan
240.50	Requirements for Returning the Student to the Regular School Program
240.60	Supplemental Services and Instructional Time
240.70	Application for Program Approval
240.75	Program Approval Criteria
240.80	Application for Program Continuation
240.90	Program Funding
240.100	Suspension and Revocation of Program Approval
240.110	Terms and Conditions of Approval

SUBPART B: ALTERNATIVE LEARNING OPPORTUNITIES PROGRAM GRANTS

240.200	Purpose
240.210	Eligible Applicants
240.220	Planning Grants
240.230	Implementation Grants
240.240	Supplemental Grants
240.250	Grant Awards
240.260	Terms of the Grant

AUTHORITY: Implementing and authorized by Article 13B of the School Code [105 ILCS 5/Art. 13B].

STATE BOARD OF EDUCATION

NOTICE OF PROPOSED RULES

SOURCE: Adopted at 26 Ill. Reg. 11888, effective July 22, 2002; amended at 27 Ill. Reg. _____, effective _____.

NOTE: Capitalization denotes statutory language.

SUBPART A: PROGRAM APPROVAL

Section 240.90 Program Funding

~~A~~ A school district or regional office of education that operates an Alternative Learning Opportunities Program approved by the State Board of Education shall be eligible to receive General State Aid, subject to subsections (a) through (c) of this Section, provided that it meets the requirements for claiming State aid specified in Section 18-8.05 of the School Code and meets the criteria specified in Sections 13B-50.5 and 13B-50.10 of the School Code [105 ILCS 5/13B-50.5 and 13B-50.10].

- a) If two or more school districts operate a program under a cooperative agreement, then the attendance shall be reported to the resident district of each student enrolled in the program and used by that district in calculating its average daily attendance for the purpose of claiming General State Aid.
- b) In instances where a school district contracts with an entity other than a regional office of education to operate a program, the attendance shall be reported to the district of each student enrolled in the program and used by the district in calculating its average daily attendance for the purpose of the district's claiming General State Aid.
- ~~c)~~ A ~~When a~~ regional office of education ~~that~~ operates an Alternative Learning Opportunities Program under a cooperative agreement with one or more school districts, it is entitled to ~~receive~~ submit a claim directly to the State Board of Education for General State Aid at the foundation level of support (see 105 ILCS 5/13B-50.15).
 - 1) The regional office of education's claim shall include only the time period during which students from the school district or districts subject to the provisions of the cooperative agreement are enrolled in the Alternative Learning Opportunities Program.

STATE BOARD OF EDUCATION

NOTICE OF PROPOSED RULES

- 2) The school district or districts subject to the provisions of the cooperative agreement shall not claim students for the time period during which those students were enrolled in the Alternative Learning Opportunities Program operated by the regional office of education.

- 3) In instances where the school district's per capita tuition charge exceeds the foundation level of support provided to the regional office of education, then it shall be the responsibility of that school district to provide for its students enrolled in the program the difference between the foundation level received by the regional office and the district's per capita tuition charge.

(Source: Amended at 27 Ill. Reg. _____, effective _____)

DEPARTMENT OF PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Occupation Therapy Practice Act
- 2) Code Citation: 68 Ill. Adm. Code 1315
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
1315.130	Amendment
1315.140	Amendment
1315.145	New Section
1315.160	Amendment
- 4) Statutory Authority: Occupational Therapy Practice Act [225 ILCS 75]
- 5) A Complete Description of the Subjects and Issues Involved: This proposed rulemaking adds Section 1315.145 to implement the continuing education requirement, as provided for in Section 11 of the Act. Other sections are amended to reflect the CE requirement.
- 6) Do these proposed amendments replace emergency rules currently in effect? No
- 7) Does this rulemaking contain an automatic repeal date? No
- 8) Do these proposed amendments contain incorporations by reference? No
- 9) Are there any other proposed amendments pending on this Part? No
- 10) Statement of Statewide Policy Objectives (if applicable):

This rulemaking has no effect on local governments.
- 11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking:

Interested persons may submit written comments to:

Department of Professional Regulation
Attention: Barb Smith
320 West Washington, 3rd Floor
Springfield, IL 62786
217/785-0813 Fax #: 217/782-7645

DEPARTMENT OF PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

All written comments received within 45 days after this issue of the Illinois Register will be considered.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Those providing occupational therapy services.

B) Reporting, bookkeeping or other procedures required for compliance:

Occupational therapists and occupational therapy assistants will be required to keep records of their continuing education.

C) Types of professional skills necessary for compliance:

Occupational therapy skills are necessary for licensure.

13) Regulatory Agenda on which this rulemaking was summarized: January 2003

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

DEPARTMENT OF PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

TITLE 68: PROFESSIONS AND OCCUPATIONS

CHAPTER VII: DEPARTMENT OF PROFESSIONAL REGULATION
SUBCHAPTER b: PROFESSIONS AND OCCUPATIONS

PART 1315

ILLINOIS OCCUPATIONAL THERAPY PRACTICE ACT

Section

- 1315.90 Application for Licensure Under Section 14 of the Act (Repealed)
- 1315.100 Approved Programs
- 1315.110 Application for Licensure
- 1315.120 Examination
- 1315.130 Fees for the Administration of the Act
- 1315.140 Renewal
- [1315.145 Continuing Education](#)
- 1315.150 Endorsement
- 1315.160 Restoration
- 1315.162 Modalities in Occupational Therapy
- 1315.163 Supervision of an Occupational Therapy Assistant
- 1315.164 Supervision of an Aide in Occupational Therapy
- 1315.165 Professional Conduct Standards
- 1315.170 Advertising
- 1315.180 Conduct of Hearings (Repealed)
- 1315.200 Granting Variances

AUTHORITY: Implementing the Illinois Occupational Therapy Practice Act [225 ILCS 75] and authorized by Section 2105-15(7) of the Civil Administrative Code of Illinois [20 ILCS 2105/15(7)].

SOURCE: Emergency rules adopted at 8 Ill. Reg. 676, effective January 1, 1984, for a maximum of 150 days; adopted at 8 Ill. Reg. 16455, effective August 28, 1984; recodified from Chapter I, 68 Ill. Adm. Code 315 (Department of Registration and Education) to Chapter VII, 68 Ill. Adm. Code 1315 (Department of Professional Regulation) pursuant to P.A. 85-225, effective January 1, 1988, at 12 Ill. Reg. 2940; amended at 18 Ill. Reg. 7373, effective May 2, 1994; amended at 18 Ill. Reg. 16615, effective October 27, 1994; amended at 23 Ill. Reg. 2304, effective January 22, 1999; amended at 26 Ill. Reg. 18330, effective December 13, 2002; amended at 27 Ill. Reg. _____, effective _____.

DEPARTMENT OF PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

Section 1315.130 Fees for the Administration of the Act

The following fees shall be paid to the Department for the functions performed by the Department under the Illinois Occupational Therapy Practice Act [225 ILCS 75] (the Act) and shall be non-refundable:

- a) Application Fees
 - 1) The fee for application for a license as an occupational therapist or occupational therapy assistant is \$25. In addition, applicants for an examination shall be required to pay, either to the Department or to the designated testing service, a fee covering the cost of determining an applicant's eligibility and providing the examination. Failure to appear for the examination on the scheduled date, at the time and place specified, after the applicant's application for examination has been received and acknowledged by the Department or the designated testing service, shall result in the forfeiture of the examination fee.
 - 2) The fee for application as a continuing education sponsor is \$250. State colleges, universities, and State agencies are exempt from payment of this fee.
- b) Renewal Fees
 - 1) The fee for the renewal of a license as an occupational therapist shall be calculated at the rate of \$20 per year.
 - 2) The fee for the renewal of a license as an occupational therapy assistant shall be calculated at the rate of \$10 per year.
 - 3) The fee for renewal of continuing education sponsor approval is \$125 for the renewal period.
- c) General Fees
 - 1) The fee for the restoration of a license other than from inactive status is \$20 plus payment of all lapsed renewal fees, but not to exceed \$110.

DEPARTMENT OF PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

- 2) The fee for the issuance of a duplicate license, for the issuance of a replacement license for a license that has been lost or destroyed or for the issuance of a license with a change of name or address, other than during the renewal period, is \$20. No fee is required for name and address changes on Department records when no duplicate license is issued.
- 3) The fee for a certification of a licensee's record for any purpose is \$20.
- 4) The fee to have the scoring of an examination authorized by the Department reviewed and verified is \$20 plus any fees charged by the applicable testing service.
- 5) The fee for a wall certificate showing licensure shall be the actual cost of producing the certificate.
- 6) The fee for a roster of persons licensed as occupational therapists or occupational therapy assistants in this State shall be the actual cost of producing the roster.

~~The fee for application and for an original license as a registered occupational therapist or certified occupational therapy assistant is \$25. In addition, applicants may be required to pay, either to the Department or to the designated testing service, a fee for the cost of providing the examination;~~

- b) ~~The fee for the renewal of a license as a registered occupational therapist is \$20 per year;~~
- e) ~~The fee for the renewal of a license as a certified occupational therapy assistant is \$10 per year;~~
- d) ~~The fee for a license as a registered occupational therapist or a certified occupational therapy assistant by endorsement from another jurisdiction is \$50;~~
- e) ~~The fee for restoration of a license that has been placed on inactive status is the current renewal fee;~~
- f) ~~The fee for restoration of a license other than from inactive status is \$10 plus payment of all lapsed renewal fees, not to exceed \$110;~~

DEPARTMENT OF PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

- ~~g) The fee for a certification of a license is \$20;~~
- ~~h) The fee for a duplicate or replacement license is \$20;~~
- ~~i) The fee for a wall certificate showing licensure is the actual cost of producing the certificate;~~
- ~~j) The fee for a change of name or address on a licensee's record, other than during renewal, is \$20;~~
- ~~k) The fee for a roster of licensees is the actual cost of producing the roster [(total number of registrants in list required) times the multiplier (cost of paper), plus fixed costs (such as personnel, handling and forms)].~~

(Source: Amended at 27 Ill. Reg. _____, effective _____)

Section 1315.140 Renewal

- a) Every license issued under the Act shall expire on December 31, of each odd numbered year. The holder of the license may renew such license during the month preceding the expiration date by paying the required fee. [Beginning with the December 31, 2005 renewal and every renewal thereafter, a renewal applicant will be required to complete 24 contact hours of continuing education as set forth in Section 1315.145 of this Part.](#)
- b) It is the responsibility of each licensee to notify the Department of any change of address. Failure to receive a renewal form from the Department shall not constitute an excuse for failure to pay the renewal fee or to renew one's license.
- c) Practicing on an expired license shall be considered unlicensed practice.

(Source: Amended at 27 Ill. Reg. _____, effective _____)

[Section 1315.145 Continuing Education](#)

- a) [Continuing Education \(CE\) Hour Requirements](#)
 - 1) [Every occupational therapist and occupational therapy assistant shall complete 24 contact hours of continuing education \(CE\) relevant to the practice of occupational therapy during each prerenewal period as a](#)

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condition of renewal. A prerenewal period is the 24 months preceding December 31 in the year of the renewal. 24 contact hours of continuing education (CE) is equivalent to 12 units of Continued Competency Activities (CCA) (2 contact hours = 1 unit).

- 2) A CE contact hour equals 50 minutes. After completion of the initial CE hour, credit may be given in one-half hour increments.
 - 3) Courses that are part of the curriculum of an accredited university, college or other educational institution shall be allotted CE credit at the rate of 15 CE hours for each semester hour or 10 CE hours for each quarter hour of school credit awarded.
 - 4) A renewal applicant is not required to comply with CE requirements for the first renewal following the original issuance of the license.
 - 5) Individuals licensed in Illinois but residing and practicing in other states must comply with the CE requirements set forth in this Section.
 - 6) All continuing education hours must be earned by verified attendance at or participation in a program which is offered by an approved continuing education sponsor who meets the requirements set forth in subsection (c) or by other CE activities set forth in subsection (b).
 - 7) Continuing education credit hours used to satisfy the CE requirements of another state may be submitted for approval for fulfillment of the CE requirements of the State of Illinois if they meet the requirements for CE in Illinois.
 - 8) Credit shall not be given for courses taken in Illinois from unapproved sponsors.
- b) Additional CE activities
- 1) Independent Study
 - A) Independent Study Activities include reading books, journal articles, reviewing professional videos, etc.

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- B) A licensee may earn contact hours spent in an independent study activity with a maximum of 4 contact hours per renewal period.
 - C) Documentation shall include title, author, publisher, time spent, and date of completion. A licensee shall include a statement that describes how the activity relates to a licensee's current or anticipated roles and responsibilities.
- 2) Mentorship
- A) Participation as Mentee
 - i) Participation in a formalized mentorship agreement with a mentor as defined by a signed contract between the mentor and mentee that outlines specific goals and objectives and designates the plan of activities that are to be met by the mentee.
 - ii) A licensee may earn contact hours spent in activities directly related to achievement of goals and objectives with a maximum of 8 contact hours per renewal period. The Department may accept formalized mentorship programs for the amount of credit recommended by the mentor not to exceed 8 hours per renewal period.
 - iii) Documentation shall include name of mentor and mentee, copy of signed contract, dates, hours spent and focus of mentorship activities, and outcomes of mentorship agreement.
 - B) Participation as Mentor
 - i) Participation in a formalized mentorship agreement with a mentee as defined by a signed contract that designates the responsibilities of the mentor and specific goals and objectives that are to be met by the mentee.

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- B) Documentation shall consist of full reference for publication including: title, author, editor, and date of publication, or copy of acceptance letter if not yet published.
- 5) Presentation and Instruction
- A) First time or significantly revised presentation of an academic course or workshop, seminar, in-service, electronic or Web-based course. Speeches made at luncheons or banquets or any other presentation not within the guidelines made in these regulations are not eligible for CE credit.
- B) A licensee who serves as an instructor, speaker or discussion leader of a CE program will be allowed CE course credit for actual presentation time, plus actual preparation time of up to 2 hours for each hour of presentation. Preparation time shall not be allowed for presentations of the same course and will only be allowed for additional study or research. In no case shall credit for actual time of presentation and preparation be given for more than 12 hours during any renewal period.
- C) Documentation shall include a copy of official program/schedule/syllabus including presentation title, date, hours of presentation, and type of audience or verification of such signed by the sponsor.
- 6) Research
- A) Development of or participation in a research project.
- B) A licensee may earn credit for hours spent working on a research project, for a maximum of 12 hours per renewal period.
- C) Documentation includes verification from the primary investigator indicating the name of the research project, dates of participation, major hypotheses or objectives of the project, and licensee's role in the project.
- 7) Grants

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- A) Development of a grant proposal.
 - B) A licensee may earn credit for hours working on a grant proposal for a maximum of 12 hours per renewal period.
 - C) Documentation includes name of grant proposal, name of grant source, purpose and objectives of the project, and verification from the grant author regarding licensee's role in the development of the grant if not the author.
- 8) Professional meetings and activities
- A) Participation in board or committee work with agencies or organizations in professionally related areas to promote and enhance the practice of occupational therapy.
 - B) A licensee may earn 2 hours per appointment on a committee or board for one year for a maximum of 8 hours per renewal period.
 - C) Documentation includes name of committee or board, name of agency or organization, purpose of service, and description of licensee's role. Participation must be validated by an officer or representative of the organization or committee.
- 9) Advanced competence recognition/specialty certification
- A) Advanced recognition and/or specialty certification from a nationally recognized certifying body or approved provider.
 - B) A licensee may earn 12 contact hours for each advanced competence recognition or specialty certification credential earned.
 - C) Documentation includes certificate of completion or other documentation that identifies satisfactory completion of requirements for obtaining advanced competence or specialty certification.
- c) Continuing Education Sponsors and Programs

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- 1) Approved sponsor, as used in this Section, shall mean:
 - A) American Occupational Therapy Association and its affiliates;
 - B) American Physical Therapy Association and the Illinois Physical Therapy Association;
 - C) AOTA Approved Providers;
 - D) American Speech and Hearing Association and the Illinois Speech and Hearing Association;
 - E) Accredited Colleges and Universities;
 - F) Any other person, firm, association, corporation, or group that has been approved and authorized by the Department pursuant to subsection (c)(2) of this Section upon the recommendation of the Board to coordinate and present continuing education courses or programs.

- 2) Entities seeking a license as a CE sponsor pursuant to subsection (1)(F) shall file a sponsor application, along with the required fee set forth in Section 1315.130. (State agencies, State colleges and State universities in Illinois shall be exempt from paying this fee.) The applicant shall certify to the following:
 - A) That all courses and programs offered by the sponsor for CE credit will comply with the criteria in subsection (c) of this Section and all other criteria in this Section. The applicant shall be required to submit a sample 3 hour CE program with course materials, presenter qualifications and course outline for review prior to being approved as a CE sponsor;
 - B) That the sponsor will be responsible for verifying attendance at each course or program, and provide a certification of attendance as set forth in subsection (c)(7) below; and
 - C) That upon request by the Department, the sponsor will submit evidence as is necessary to establish compliance with this Section. This evidence shall be required when the Department has reason to

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believe that there is not full compliance with the statute and this Part and that this information is necessary to ensure compliance.

- 3) Each sponsor shall submit by December 31 of each odd numbered year a sponsor application along with the renewal fee set forth in Section 1315.130. With the application the sponsor shall be required to submit to the Department a list of all courses and programs offered in the prerenewal period, which includes a description, location, date and time the course was offered.
- 4) Each CE program shall provide a mechanism for written evaluation of the program and instructor by the participants. The evaluation forms shall be kept for 5 years and shall be made available to the Department upon written request.
- 5) All courses and programs shall:
 - A) Contribute to the advancement, extension and enhancement of professional clinical skills and scientific knowledge in the practice of occupational therapy;
 - B) Provide experiences which contain scientific integrity, relevant subject matter and course materials; and
 - C) Be developed and presented by persons with education and/or experience in the subject matter of the program.
- 6) All programs given by approved sponsors shall be open to all licensees and not be limited to the members of a single organization or group and shall specify the number of CE hours that may be applied toward Illinois CE requirements for licensure renewal.
- 7) Certificate of Attendance
 - A) It shall be the responsibility of the sponsor to provide each participant in a program with a certificate of attendance signed by the sponsor. The sponsor's certificate of attendance shall contain:
 - i) The name and address of the sponsor;

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- ii) The name and address of the participant and his/her license number;
 - iii) A detailed statement of the subject matter;
 - iv) The number of hours actually attended in each topic;
 - v) The date of the program; and
 - vi) Signature of the sponsor.
- B) The sponsor shall maintain these records for not less than 5 years.
- 8) The sponsor shall be responsible for assuring verified continued attendance at each program. No renewal applicant shall receive credit for time not actually spent attending the program.
- 9) Upon the failure of a sponsor to comply with any of the foregoing requirements, the Department, after notice to the sponsor and hearing before and recommendation by the Board pursuant to the Administrative Hearing Rules (see 68 Ill. Adm. Code 1110) shall thereafter refuse to accept CE credit for attendance at or participation in any of that sponsor's CE programs until such time as the Department receives reasonably satisfactory assurances of compliance with this Section.
- e) Continuing Education Earned in Other Jurisdictions
- 1) If a licensee has earned CE hours in another jurisdiction from a nonapproved sponsor for which he/she will be claiming credit toward full compliance in Illinois, that applicant shall submit an application along with a \$20 processing fee prior to taking the program or 90 days prior to the expiration date of the license. The Board shall review and recommend approval or disapproval of this program using the criteria set forth in this Section.
- 2) If a licensee fails to submit an out of state CE approval form within the required time, late approval may be obtained by submitting the application with the \$20 processing fee plus a \$10 per hour late fee not to exceed \$150. The Board shall review and recommend approval or disapproval of this program using the criteria set forth in this Section.
- f) Certification of Compliance with CE Requirements

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- 1) Each renewal applicant shall certify, on the renewal application, full compliance with CE requirements set forth in subsection (a) above.
 - 2) The Department may require additional evidence demonstrating compliance with the CE requirements. It is the responsibility of each renewal applicant to retain or otherwise produce evidence of compliance.
 - 3) When there appears to be a lack of compliance with CE requirements, an applicant will be notified and may request an interview with the Board, at which time the Board may recommend that steps be taken to begin formal disciplinary proceedings as required by Section 10-65 of the Illinois Administrative Procedure Act [5 ILCS 100/10-65].
- g) Waiver of CE Requirements
- 1) Any renewal applicant seeking renewal of his/her license without having fully complied with these CE requirements shall file with the Department a renewal application, the renewal fee set forth in Section 1315.130, a statement setting forth the facts concerning the non-compliance, and a request for waiver of the CE requirements on the basis of these facts. If the Department, upon the written recommendation of the Board, finds from the affidavit or any other evidence submitted that good cause has been shown for granting a waiver, the Department shall waive enforcement of these requirements for the renewal period for which the applicant has applied.
 - 2) Good cause shall be defined as an inability to devote sufficient hours to fulfilling the CE requirements during the applicable prerenewal period because of:
 - A) Full-time service in the armed forces of the United States of America during a substantial part of such period; or
 - B) Extreme hardship, which shall be determined on an individual basis by the Board and shall be limited to documentation of:
 - i) An incapacitating illness documented by a currently licensed physician;

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- ii) A physical inability to travel to the sites of approved programs; or
 - iii) Any other similar extenuating circumstances.
- 3) If an interview with the Board is requested at the time the request for the waiver is filed with the Department, the renewal applicant shall be given at least 20 days written notice of the date, time and place of the interview by certified mail, return receipt requested.
- 4) Any renewal applicant who submits a request for waiver pursuant to subsection (f)(1) of this Section shall be deemed to be in good standing until the Department's final decision on the application has been made.

(Source: Added at 27 Ill. Reg. _____, effective _____)

Section 1315.160 Restoration

- a) A person seeking restoration of a license that has expired or been placed on inactive status for 5 years or more shall file an application with the Department, on forms supplied by the Department, along with the required fees specified in Section 1315.130 of this Part. The applicant shall also submit one of the following:
- 1) Sworn evidence of active practice in another jurisdiction. Such evidence shall include a statement from the appropriate board or licensing authority in the other jurisdiction that the licensee was authorized to practice during the term of said active practice;
 - 2) An affidavit attesting to military service as provided in Section 11 of the Act (no fee is required when restoring from a period of military service if application is made within 2 years after termination of the service);
 - 3) Verification of successful completion of the Certification Examination of the NBCOT for licensure as a registered occupational therapist or certified occupational therapy assistant within the last 5 years prior to applying for restoration; or

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- 4) Evidence of successful completion of 48 hours of continuing education ~~recent attendance at educational programs~~ in occupational therapy, including attendance at college level courses, professionally oriented continuing education classes, special seminars, or any other similar program; completed within 2 years prior to application for restoration ~~or evidence of recent related work experience to show that the applicant has maintained competence in his/her field.~~
- b) A registrant seeking restoration of a license that has been expired for less than 5 years shall have the license restored upon payment of \$~~20~~ 40 plus all lapsed renewal fees required by Section 1315.130 of this Part. A licensee seeking restoration of a license shall be required to submit proof of the required 24 hours of continuing education in accordance with Section 1315.145. These CE hours shall be earned within the 2 years prior to renewal.
- c) A registrant seeking restoration of a license that has been on inactive status for less than 5 years shall have the license restored upon payment of the current renewal. A licensee seeking restoration of a license shall be required to submit proof of the required 24 hours of continuing education in accordance with Section 1315.145. These CE hours shall be earned within the 2 years prior to renewal.
- d) When the accuracy of any submitted documentation or the relevance or sufficiency of the course work or experience is questioned by the Department or the Board because of lack of information, discrepancies or conflicts in information given or a need for clarification, the applicant seeking licensure shall be requested to:
- 1) Provide such information as may be necessary; and/or
 - 2) Appear for an interview before the Board to explain such relevance or sufficiency, clarify information, or clear up any discrepancies or conflicts in information.

(Source: Amended at 27 Ill. Reg. _____, effective _____)

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- 1) Heading of the Part: Control of Communicable Disease Code
- 2) Code Citation: 77 Ill. Adm. Code 690
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
690.100	Amendment
690.655	Added
- 4) Statutory Authority: Implementing Communicable Disease Report Act [745 ILCS 45], and implementing and authorized by the Department of Public Health Act [20 ILCS 2305].
- 5) A Complete Description of the Subjects and Issues Involved: The proposed amendments require the reporting of complications of vaccination for smallpox by telephone or electronically as soon as possible, within 24 hours of diagnosis. Complications of vaccination for smallpox include, but are not limited to, the following:eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, autoinoculation, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the vaccination site, vaccinia transmission to contacts, and other adverse events resulting in hospitalization, permanent disability, life-threatening illness, or death.
- 6) Will this proposed rule replace an emergency rule in effect? Yes
- 7) Does this rulemaking contain an automatic repeal date? No
- 8) Does this proposed amendment 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 create or expand a State Mandate under the State Mandate Act [30 ILCS 805].
- 11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking:

Interested persons may present their comments concerning this rulemaking within 45 days after this issue of the *Illinois Register* to:

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Peggy Snyder
Division of Legal Services
Illinois Department of Public Health
535 West Jefferson St., 5th Floor
Springfield, Illinois 62761
217/782-2043
e-mail: rules@idph.state.il.us

- 12) Initial Regulatory Flexibility Analysis.
 - a) Type of Small Businesses, Small Municipalities, and Not-for-Profit Corporations affected: Units of local government.
 - b) Reporting, Bookkeeping, or Other Procedures required for compliance: Reporting of adverse affects.
 - c) Types of Professional Skills necessary for compliance: None.
- 13) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on the most recent Regulatory Agenda because the decision to propose this rulemaking had not been made when the Regulatory Agenda was finalized.

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

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TITLE 77: PUBLIC HEALTH

CHAPTER I: DEPARTMENT OF PUBLIC HEALTH

SUBCHAPTER k: COMMUNICABLE DISEASE CONTROL AND IMMUNIZATIONS

PART 690

CONTROL OF COMMUNICABLE DISEASES CODE

SUBPART A: REPORTABLE DISEASES AND CONDITIONS

Section	
690.100	Diseases and Conditions
690.110	Diseases Repealed From This Part

SUBPART B: REPORTING

Section	
690.200	Reporting

SUBPART C: DETAILED PROCEDURES FOR THE CONTROL OF
COMMUNICABLE DISEASES

Section	
690.290	Acquired Immunodeficiency Syndrome (AIDS) (Repealed)
690.295	Any Unusual Case or Cluster of Cases That May Indicate a Public Health Hazard (Reportable by telephone as soon as possible, within 24 hours)
690.300	Amebiasis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
690.310	Animal Bites (Reportable by mail or telephone as soon as possible, within 7 days) (Repealed)
690.320	Anthrax (Reportable by telephone immediately, within 3 hours upon initial clinical suspicion of the disease)
690.325	Blastomycosis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
690.327	Botulism, Foodborne, Infant, Wound, Other (Reportable by telephone immediately, within 3 hours upon initial clinical suspicion of the disease for foodborne or within 24 hours for other types)
690.330	Brucellosis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)

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- 690.335 Campylobacteriosis (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.340 Chancroid (Repealed)
- 690.350 Chickenpox (Varicella) (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.360 Cholera (Reportable by telephone as soon as possible, within 24 hours)
- 690.365 Cryptosporidiosis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.368 Cyclosporiasis (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.370 Diarrhea of the Newborn (Reportable by telephone as soon as possible, within 24 hours)
- 690.380 Diphtheria (Reportable by telephone as soon as possible, within 24 hours)
- 690.385 Ehrlichiosis, Human Granulocytic (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.386 Ehrlichiosis, Human Monocytic (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.390 Encephalitis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.400 Enteric Escherichia coli Infections (E. coli: 0157:H7 and Other Enterohemorrhagic E. coli, Enterotoxigenic E. coli, and Enteropathogenic E. coli) (Reportable by telephone as soon as possible, within 24 hours)
- 690.410 Foodborne or Waterborne Illness (Reportable by telephone as soon as possible, within 24 hours)
- 690.420 Giardiasis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.430 Gonorrhea (Repealed)
- 690.440 Granuloma Inguinale (Repealed)
- 690.441 Haemophilus influenzae, Meningitis and Other Invasive Disease (Reportable by telephone, within 24 hours)
- 690.442 Hantavirus Pulmonary Syndrome (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.444 Hemolytic Uremic Syndrome, Post-diarrheal (Reportable by telephone, within 24 hours)
- 690.450 Hepatitis A (Reportable by telephone as soon as possible, within 24 hours)
- 690.451 Hepatitis B (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.452 Hepatitis C Infection (Reportable by mail, telephone, facsimile or electronically, within 7 days)

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- 690.453 Hepatitis, Viral, Other (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.460 Histoplasmosis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.470 Intestinal Worms (Reportable by mail or telephone as soon as possible, within 7 days) (Repealed)
- 690.475 Legionnaires' Disease (Legionellosis) (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.480 Leprosy (Hansen's Disease) (infectious and non-infectious cases are reportable) (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.490 Leptospirosis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.495 Listeriosis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.500 Lymphogranuloma Venereum (Lymphogranuloma Inguinale Lymphopathia Venereum) (Repealed)
- 690.505 Lyme Disease (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.510 Malaria (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.520 Measles (Reportable by telephone as soon as possible, within 24 hours)
- 690.530 Meningitis, Aseptic (Including Arboviral Infections) (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.540 Meningococemia (Reportable by telephone as soon as possible) (Repealed)
- 690.550 Mumps (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.555 Neisseria meningitidis, Meningitis and Invasive Disease (Reportable by telephone as soon as possible, within 24 hours)
- 690.560 Ophthalmia Neonatorum (Gonococcal) (Reportable by mail or telephone as soon as possible, within 7 days) (Repealed)
- 690.570 Plague (Reportable by telephone immediately, within 3 hours upon initial clinical suspicion of the disease)
- 690.580 Poliomyelitis (Reportable by telephone as soon as possible, within 24 hours)
- 690.590 Psittacosis (Ornithosis) (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.595 Q-fever (Reportable by telephone immediately, within 3 hours upon initial clinical suspicion of the disease)
- 690.600 Rabies, Human (Reportable by telephone as soon as possible, within 24 hours)

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- 690.601 Rabies, Potential Human Exposure (Reportable by telephone, within 24 hours)
- 690.610 Rocky Mountain Spotted Fever (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.620 Rubella (German Measles) (Including Congenital Rubella Syndrome) (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.630 Salmonellosis (Other than Typhoid Fever) (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.640 Shigellosis (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.650 Smallpox (Reportable by telephone immediately, within 3 hours upon initial clinical suspicion of the disease)
- 690.660 Staphylococcus aureus Infections Occurring In Infants Under 28 Days of Age Within a Health Care Institution or With Onset After Discharge (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.661 Staphylococcus aureus Infections with Intermediate or High Level Resistance to Vancomycin (Reportable by telephone, within 24 hours)
- 690.670 Streptococcal Infections, Group A, Invasive Disease (Including Toxic Shock Syndrome) and Sequelae to Group A Streptococcal Infections (rheumatic fever and acute glomerulonephritis)(Reportable by telephone, within 24 hours)
- 690.675 Streptococcal Infections, Group B, Invasive Disease, of the Newborn (birth to 3 months) (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.678 Streptococcus pneumoniae, Invasive Disease (Including Antibiotic Susceptibility Test Results) (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.680 Syphilis (Repealed)
- 690.690 Tetanus (Reportable by mail, telephone, facsimile or electronically, within 7 days)
- 690.695 Staphylococcus aureus Infection, Toxic Shock Syndrome (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.700 Trachoma (Repealed)
- 690.710 Trichinosis (Trichinellosis) (Reportable by mail, telephone, facsimile or electronically as soon as possible, within 7 days)
- 690.720 Tuberculosis (Repealed)
- 690.725 Tularemia (Reportable by telephone immediately, within 3 hours upon initial clinical suspicion of the disease)
- 690.730 Typhoid Fever (Reportable by telephone as soon as possible, within 24 hours)
- 690.740 Typhus (Reportable by telephone as soon as possible, within 24 hours)
- 690.750 Pertussis (Whooping Cough) (Reportable by telephone as soon as possible, within 24 hours)

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690.752 Yersiniosis (Reportable by mail, telephone, facsimile or electronically, within 7 days)

690.800 Any Suspected Bioterrorist Threat or Event (Reportable by telephone immediately, within 3 hours upon initial clinical suspicion of the disease)

SUBPART D: DEFINITIONS

Section

690.900 Definition of Terms

SUBPART E: GENERAL PROCEDURES

Section

690.1000 General Procedures for the Control of Communicable Diseases

690.1010 Incorporated Materials

SUBPART F: SEXUALLY TRANSMITTED DISEASES (Repealed)

Section

690.1100 The Control of Sexually Transmitted Diseases (Repealed)

SUBPART G: PROCEDURES FOR WHEN DEATH OCCURS FROM
COMMUNICABLE DISEASES

Section

690.1200 Death of a Person Who Had a Known or Suspected Communicable Disease

690.1210 Funerals (Repealed)

EXHIBIT A Typhoid Fever Agreement (Repealed)

SUBPART A: REPORTABLE DISEASES AND CONDITIONS

Section 690.100 Diseases and Conditions

The following are declared to be contagious, infectious, communicable and dangerous to the public health and each suspected or diagnosed case shall be reported to the local health authority who shall subsequently report each case to the Illinois Department of Public Health. This listing includes those diseases and conditions reportable because of classification as communicable or sexually transmitted. Communicable diseases and conditions are reportable under this Part (77 Ill. Adm. Code 690) and sexually transmissible diseases and conditions are reportable under the

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Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). (See Subpart B, Section 690.200.)

- a) Class I(a)
 The following diseases shall be reported immediately (within 3 hours) upon initial clinical suspicion of the disease to the local health authorities, who shall then report to the Department immediately (within 3 hours). This interval applies to primary reporters identified in Section 690.200(a)(1) who are required to report to local health authorities and to local health authorities who are required to report to the Department. The Section number associated with each of the listed diseases indicates the Part under which the diseases are reportable.
- | | | |
|----|--|---------|
| 1) | Anthrax | 690.320 |
| 2) | Botulism, foodborne | 690.327 |
| 3) | Plague | 690.570 |
| 4) | Q-fever | 690.595 |
| 5) | Smallpox | 690.650 |
| 6) | Tularemia | 690.725 |
| 7) | Any suspected bioterrorist threat or event | 690.800 |
- b) Class I(b)
 The following diseases shall be reported as soon as possible during normal business hours, but within 24 hours (i.e., within 8 regularly scheduled business hours after identifying the case), to the local health authorities, who shall then report to the Department as soon as possible, but within 24 hours. This interval applies to primary reporters identified in Section 690.200(a)(1) who are required to report to local health authorities and to local health authorities who are required to report to the Department. The Section number associated with each of the listed diseases indicates the Part under which the diseases are reportable.
- | | |
|----|---|
| | Section |
| 1) | Any unusual case or cluster of cases that may indicate a public health hazard |

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- | | |
|---|----------------|
| | 690.295 |
| 2) Botulism, infant, wound, and other | 690.327 |
| 3) Cholera | 690.360 |
| 4) Diarrhea of the newborn | 690.370 |
| 5) Diphtheria | 690.380 |
| 6) Enteric Escherichia coli infections
(E. coli: 0157:H7 and other
enterohemorrhagic E. coli, enterotoxigenic E. coli,
enteropathogenic E. coli) | 690.400 |
| 7) Foodborne or waterborne illness | 690.410 |
| 8) Haemophilus influenzae, meningitis and
other invasive disease | 690.441 |
| 9) Hemolytic uremic syndrome, post-diarrheal | 690.444 |
| 10) Hepatitis A | 690.450 |
| 11) Measles | 690.520 |
| 12) Neisseria meningitidis, meningitis
and invasive disease | 690.555 |
| 13) Pertussis (whooping cough) | 690.750 |
| 14) Poliomyelitis | 690.580 |
| 15) Rabies, human | 690.600 |
| 16) Rabies, potential human exposure | 690.601 |
| <u>17) Smallpox, complications of vaccination for</u> | <u>690.655</u> |
| <u>18) 17) Staphylococcus aureus infections with</u> | |

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intermediate or high level resistance to
vancomycin *

690.661

19)~~18)~~ Streptococcal infections, Group A,
invasive (including toxic shock syndrome)
and sequelae to Group A streptococcal
infections (rheumatic fever and acute
glomerulonephritis)

690.670

20)~~19)~~ Typhoid fever*

690.730

21)~~20)~~ Typhus

690.740

c) Class II

The following diseases shall be reported as soon as possible during normal business hours, but within 7 days, to the local health authority which shall then report to the Department within 7 days. The Section number associated with each of the listed diseases indicates the Part under which the diseases are reportable.

	Section
1) Acquired immunodeficiency syndrome (AIDS)	693.20
2) Amebiasis*	690.300
3) Blastomycosis	690.325
4) Brucellosis	690.330
5) Campylobacteriosis*	690.335
6) Chancroid	693.20
7) Chickenpox	690.350
8) Chlamydia	693.20
9) Cryptosporidiosis	

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	690.365
10) Cyclosporiasis	
	690.368
11) Ehrlichiosis, human granulocytic	
	690.385
12) Ehrlichiosis, human monocytic	
	690.386
13) Encephalitis	
	690.390
14) Giardiasis*	
	690.420
15) Gonorrhea	
	693.20
16) Hantavirus pulmonary syndrome	
	690.442
17) Hepatitis B*	
	690.451
18) Hepatitis C*	
	690.452
19) Hepatitis, viral, other*	
	690.453
20) Histoplasmosis	
	690.460
21) Human immunodeficiency virus (HIV) infection	
	693.20
22) Legionnaires' disease (legionellosis)	
	690.475
23) Leprosy	
	690.480
24) Leptospirosis	
	690.490
25) Listeriosis	
	690.495
26) Lyme disease	
	690.505
27) Malaria	
	690.510
28) Meningitis, aseptic (including arboviral infections)	

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	690.530
29) Mumps	
	690.550
30) Ophthalmia neonatorum (gonococcal)	
	693.20
31) Psittacosis	
	690.590
32) Rocky Mountain spotted fever	
	690.610
33) Rubella, including congenital rubella syndrome	
	690.620
34) Salmonellosis* (other than typhoid fever)	
	690.630
35) Shigellosis*	
	690.640
36) Staphylococcus aureus infection, toxic shock syndrome	
	690.695
37) Staphylococcus aureus infections occurring in infants under 28 days of age (within a health care institution or with onset after discharge)	
	690.660
38) Streptococcal infections, group B, invasive disease, of the newborn	
	690.675
39) Streptococcus pneumoniae, invasive disease * (including antibiotic susceptibility test results)	
	690.678
40) Syphilis	
	693.20
41) Tetanus	
	690.690
42) Trichinosis	
	690.710
43) Tuberculosis	
	696.170
44) Yersiniosis	
	690.752

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*Cases and carriers (when carriers are required to be reported) of these diseases should be confirmed by appropriate laboratory tests before reporting.

- d) When an epidemic of a disease dangerous to the public health occurs, and present rules are not adequate for its control or prevention, more stringent requirements shall be issued by this Department.

(Source: Amended at 27 Ill. Reg. _____, effective _____)

SUBPART C: DETAILED PROCEDURES FOR THE CONTROL OF
COMMUNICABLE DISEASES

Section 690.655 Smallpox, complications of vaccination for (Reportable by telephone or electronically as soon as possible, within 24 hours)

- a) Complications of vaccination for smallpox include, but are not limited to, the following: eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, autoinoculation, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the vaccination site, vaccinia transmission to contacts, and other adverse events resulting in hospitalization, permanent disability, life-threatening illness, or death.
- b) Incubation Period - most complications occur within 14-28 days of vaccination, complications may occur later (e.g. vaccinia infection in contacts, fetal vaccinia).
- c) Control of case and contacts. Isolation and infection control precautions for individuals with vaccinia complications vary depending upon the type of complication.
- d) Laboratory reporting. As laboratory tests become available to identify vaccinia virus as the cause of complication, laboratories shall be required to report positive test results and accompanying demographic information.
- e) Reporting of cases. Complications of smallpox vaccination shall be reported to the local health department within 24 hours of diagnosis.

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(Source: Added at 27 Ill. Reg. _____, effective _____)

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- 1) Heading of the Part: Reimbursement for Expenses
- 2) Code Citation: 20 Ill. Adm. Code 110
- 3)

<u>Section Numbers:</u>	<u>Adopted Action:</u>
110.10	Amendment
110.15	Amendment
110.25	Amendment
110.30	Amendment
110.35	Amendment
- 4) Statutory Authority: Implementing Section 3-7-6 and authorized by Section 3-2-2 of the Unified Code of Corrections [730 ILCS 5/3-7-6 and 3-2-2].
- 5) Effective Date of Amendments. March 1, 2003
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this amendment contain incorporations by reference? Yes
- 8) A statement that a copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice(s) of Proposal Published in Illinois Register:

<u>12/6/2002</u>	<u>26 Ill. Reg. 17329</u>
(issue date)	
- 10) Has JCAR issued a Statement of Objections to this (these) rule(s)? No
- 11) Difference(s) 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 rule (amendment, repealer) currently in effect? No

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- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendments: This rulemaking is to update procedures concerning the recovery cost of incarceration and require committed persons to provide financial information on a form prescribed by the Department in accordance with Public Act 92-564. Additionally, this rulemaking notifies the public that the offender's failure to cooperate and to provide requested financial information may result in discipline.
- 16) Information and questions regarding this adopted amendment shall be directed to:

Name: Beth Kiel
Department of Corrections
Address: 1301 Concordia Court
P. O. Box 19277
Springfield, Illinois 62794-9277
Telephone: 217/522-2666, extension 6511

The full text of the Adopted Rule(s) (Amendments) begins on the next page:

DEPARTMENT OF CORRECTIONS

NOTICE OF ADOPTED AMENDMENTS

TITLE 20: CORRECTIONS, CRIMINAL JUSTICE, AND LAW ENFORCEMENT

CHAPTER 1: DEPARTMENT OF CORRECTIONS
SUBCHAPTER a: ADMINISTRATION AND RULESPART 110
REIMBURSEMENT FOR EXPENSES

SECTION

110.10	Applicability
110.15	Definitions
110.20	Responsibilities
110.25	Charges for Expenses for Costs of Incarceration
110.30	Responsibilities of Offender Liability for Expenses
110.35	Guidelines for Referral to Attorney General

AUTHORITY: Implementing Section 3-7-6 and authorized by Section 3-2-2 of the Unified Code of Corrections [730 ILCS 5/3-7-6 and 3-2-2].

SOURCE: Adopted at 21 Ill. Reg. 9758 effective July 15, 1997. Amended at 27 Ill. Reg. 4357 effective March 1, 2003.
Section 110.10 Applicability

This Part applies to the ~~adult and juvenile facilities within Adult and Juvenile Divisions of~~ the Department of Corrections.

(Amended at 27 Ill. Reg. 4357 effective March 1, 2003)

Section 110.15 Definitions

"Assets" as defined in Section 3-7-6 of the Unified Code of Corrections [730 ILCS 5/3-7-6] means any property, tangible or intangible, real or personal, belonging to or due to an offender from social security, worker's compensation, veteran's compensation, pension benefits, or from any other source whatsoever and any and all assets and property of whatever character held in the name of the ~~offender~~~~convicted person~~, held for the benefit of the ~~offender~~~~person~~, or payable or otherwise deliverable to the ~~offender~~~~person~~. Any trust, or portion of a trust, of which ~~an offender~~~~convicted person~~ is a beneficiary shall be construed as an asset of the person if under terms of the trust benefits are required to be payable to the ~~offender~~~~person~~.

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"Average per capita cost" means the amount calculated for the average per capita cost per day for all ~~offenderseonvicted persons~~ of a particular correctional facility for the fiscal year for which the rate is being calculated.

~~"Offendereonvicted person" means a person who, through judicial determination, has been placed in the custody of the Department on the basis of a conviction as an adult a person who has been sentenced and is presently or was previously committed to the Department.~~

"Department" means the Department of Corrections.

"Director" means the Director of the Department of Corrections.

"Gang-related activity" has the same meaning ascribed to it ~~as~~ in Section 10 of the Illinois Streetgang Terrorism Omnibus Prevention Act [740 ILCS 147/10].

(Amended at 27 Ill. Reg. 4357 effective March 1, 2003)

Section 110.25 Charges for Expenses for Costs of Incarceration

- a) The time period for determining the costs of incarcerating ~~an offender a convicted person~~ shall be calculated from the date the ~~offender person~~ was confined within the Department or from July 1, 1982, whichever date is later, until the date the ~~offender person~~ is released.
- b) The maximum rate at which sums shall be charged for the expenses incurred by ~~an offender a convicted person committed to a Department correctional facility~~ for his or her incarceration shall be computed as the average per capita cost ~~per day~~ for all ~~offendereonvicted persons~~ of the particular correctional facility in which the ~~offendereonvicted person~~ is incarcerated for the fiscal year during which the ~~offendereonvicted person~~ was incarcerated or the average per capita cost for the most recent fiscal year in which a final average per capita cost is known.
- c) The average per capita cost of incarceration for a given Department correctional facility shall be computed by determining the total amount of operational expenditures for a given fiscal year for the particular correctional facility and dividing the expenditures by the average daily ~~offendereonvicted person~~ population for that particular correctional facility during that fiscal

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year.

- d) The average per capita cost ~~per day~~ for each Department correctional facility shall be recalculated annually by the Department as soon as the figures of the preceding fiscal year are available.
- e) The ~~offender~~~~convicted person~~ shall be charged for the time housed at each correctional facility.
- f) Payments received on behalf of a particular ~~offender~~~~convicted person~~, regardless of source, shall be accepted and credited against the expenses charged to the particular ~~offender~~~~convicted person~~.

(Amended at 27 Ill. Reg. 4357 effective March 1, 2003)

Section 110.30 ~~Responsibility of Offender~~Liability for Expenses

- a) ~~An offender~~~~A convicted person committed to a Department correctional facility~~ shall be responsible for reimbursing the Department for the expenses incurred by his or her incarceration or for the expenses incurred during incarceration as provided by statute and 20 Ill. Adm. Code 405 and 415 ~~Department rules~~, such as educational, medical, or dental expenses.
- b) Offenders shall fully cooperate with the Department by providing complete financial information on the financial status report form. The form shall include, but not be limited to:
 - 1) Offender's age;
 - 2) Offender's marital status;
 - 3) Number and ages of the offender's dependent children and other dependents;
 - 4) Type and value of real estate;
 - 5) Type and value of personal property;

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- 6) Cash and bank accounts;
 - 7) Location of any lock boxes;
 - 8) Type and value of investments, pensions, annuities;
 - 9) Other assets of significant cash value such as jewelry, art work, collectables, and dental and medical insurance policies; and
 - 10) Other information deemed pertinent in the investigation of assets.
- c) All offenders in the custody of the Department on January 1, 2003 and all offenders entering the Department thereafter shall complete the financial information form and shall swear under oath or affirm that to the best of his or her knowledge, the information is complete and accurate.
 - d) Offenders shall periodically update their financial information as requested by the Department.
 - e) Any offender who willfully refuses to cooperate in providing financial information shall be subject to disciplinary action, including loss of good conduct credits towards his or her sentence of up to 180 days.

(Amended at 27 Ill. Reg. 4357 effective March 1, 2003)

Section 110.35 Guidelines for Referral to Attorney General

- a) The Director may, when he or she knows or reasonably believes that ~~an offender~~~~a convicted person committed to a Department correctional facility~~ or the estate of that ~~offender~~~~person~~ has assets which may be used to satisfy all or part of a judgment rendered under Section 3-7-6 of the Unified Code of Corrections [730 ILCS 5/3-7-6] or when he or she knows or reasonably believes that ~~an offender~~~~a convicted person committed to a Department correctional facility~~ is engaged in a gang-related activity and has a substantial sum of money or other assets. ;
- b) Provide for the forwarding to the Attorney General of a report on the offender and that report shall contain a completed financial status form

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together with all other information available concerning the assets of the offender and an estimate of the total expenses for that offender.

c) ~~Authorize~~authorize the Attorney General to institute proceedings to require the ~~offendereonvicted person~~ or the estate of that ~~offenderperson~~ to reimburse the Department for expenses incurred by the ~~offender's~~convicted person's incarceration.

~~b) — The Director shall refrain from authorizing the Attorney General to institute proceedings to require convicted person or the estate of that person to reimburse the Department for the expenses incurred by the convicted person's incarceration when he or she knows or reasonably believes the convicted person or their estate does not have assets in excess of the exemptions from enforcement provided for by Sections 12-704, 12-803, 12-804, 12-901, or 12-1001 of the Code of Civil Procedure [735 ILCS 5/12-704, 12-803, 12-804, 12-901, or 12-1001] or any federal statute or case law exempting the asset in question.~~

(Amended at 27 Ill. Reg. 4357 effective March 1, 2003)

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~~subsection (b) will apply to services provided on or after October 16, 2002. For services approved by Medicare but not covered by Medicaid, the Department will reimburse qualified providers who render services to QMBs at the full Medicare deductible and coinsurance rate.~~

No other substantive changes have been made.

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will these amendments replace emergency amendments currently in effect? Yes
- 14) Are there any other amendments pending on this Part? Yes

<u>Sections</u>	<u>Proposed Action</u>	<u>Illinois Register Citation</u>
140.20	Amendment	March 15, 2002 (26 Ill. Reg. 3852)
140.530	Amendment	August 30, 2002 (26 Ill. Reg. 13026)
140.860	New Section	September 6, 2002 (26 Ill. Reg. 13146)

- 15) Summary and Purpose of Amendments:

Section 140.3

These amendments relate to the KidCare Parent Coverage Waiver program which has been approved by the federal Department of Health and Human Services. Under this program, which is designed to assist families with obtaining coverage for necessary medical services, the income eligibility standard for a parent or another adult caretaker relative who is 19 years of age or older is being increased to 49 percent of the Federal Poverty Level. The changes specify medical assistance coverage under this new Waiver.

This waiver will also affect the Children=s Health Insurance Program by allowing federal matching funds at 50 percent for KidCare Rebate. Currently, no federal match is provided to the State under KidCare Rebate.

Related amendments concerning the KidCare Parent Coverage Waiver are also being adopted at 89 Ill. Adm. Code 120 and 89 Ill. Adm. Code 125.

Section 140.21

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These changes pertain to Medicaid coverage for Qualified Medicare Beneficiaries (QMBs). The changes require pharmacies and providers of durable medical supplies to bill Medicare prior to billing the Department for certain drugs and supplies provided to Medicaid beneficiaries who are also enrolled in the federal Medicare program. Once Medicare has adjudicated the claim, any liability remaining for the Department, in the form of coinsurance and deductibles, will be reimbursed at the full Medicare allowable rate. The changes pertain to three groups of individuals, including QMB eligible medical assistance recipients, QMB eligible only recipients, and individuals who are entitled to Medicare Part A or Part B and are eligible for some form of Medicaid benefits. These proposed changes are expected to result in an estimated annual savings of \$20 million.

Other amendments will affect the amount of reimbursement provided for services approved by Medicare, but not covered by Medicaid, that is paid to providers of medical services for QMBs. The Department will provide payment at 80 percent, rather than 100 percent, of the full Medicare allowable charge when determining the amount of deductible and coinsurance due to the provider. The Department anticipates that these changes will result in an annual savings of approximately \$158,200.

- 16) Information and questions regarding these adopted amendments shall be directed 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 full text of the adopted amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMSPART 140
MEDICAL PAYMENT

SUBPART A: GENERAL PROVISIONS

Section

- 140.1 Incorporation By Reference
- 140.2 Medical Assistance Programs
- 140.3 Covered Services Under Medical Assistance Programs
- 140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
- 140.5 Covered Medical Services Under General Assistance
- 140.6 Medical Services Not Covered
- 140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
- 140.8 Medical Assistance For Qualified Severely Impaired Individuals
- 140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
- 140.10 Medical Assistance Provided to Incarcerated Persons

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section

- 140.11 Enrollment Conditions for Medical Providers
- 140.12 Participation Requirements for Medical Providers
- 140.13 Definitions
- 140.14 Denial of Application to Participate in the Medical Assistance Program
- 140.15 Recovery of Money
- 140.16 Termination or Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.18 Effect of Termination on Individuals Associated with Vendor

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- 140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension or Barring
- 140.20 Submittal of Claims
- 140.21 [Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits](#) ~~Covered Medicaid Services for Qualified Medicare Beneficiaries (QMBs)~~
- 140.22 Magnetic Tape Billings (Repealed)
- 140.23 Payment of Claims
- 140.24 Payment Procedures
- 140.25 Overpayment or Underpayment of Claims
- 140.26 Payment to Factors Prohibited
- 140.27 Assignment of Vendor Payments
- 140.28 Record Requirements for Medical Providers
- 140.30 Audits
- 140.31 Emergency Services Audits
- 140.32 Prohibition on Participation, and Special Permission for Participation
- 140.33 Publication of List of Terminated, Suspended or Barred Entities
- 140.35 False Reporting and Other Fraudulent Activities
- 140.40 Prior Approval for Medical Services or Items
- 140.41 Prior Approval in Cases of Emergency
- 140.42 Limitation on Prior Approval
- 140.43 Post Approval for items or Services When Prior Approval Cannot Be Obtained
- 140.55 Recipient Eligibility Verification (REV) System
- 140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments
- 140.72 Drug Manual (Recodified)
- 140.73 Drug Manual Updates (Recodified)

SUBPART C: PROVIDER ASSESSMENTS

- Section
- 140.80 Hospital Provider Fund
- 140.82 Developmentally Disabled Care Provider Fund
- 140.84 Long Term Care Provider Fund
- 140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
- 140.95 Hospital Services Trust Fund
- 140.96 General Requirements (Recodified)

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- 140.97 Special Requirements (Recodified)
- 140.98 Covered Hospital Services (Recodified)
- 140.99 Hospital Services Not Covered (Recodified)
- 140.100 Limitation On Hospital Services (Recodified)
- 140.101 Transplants (Recodified)
- 140.102 Heart Transplants (Recodified)
- 140.103 Liver Transplants (Recodified)
- 140.104 Bone Marrow Transplants (Recodified)
- 140.110 Disproportionate Share Hospital Adjustments (Recodified)
- 140.116 Payment for Inpatient Services for GA (Recodified)
- 140.117 Hospital Outpatient and Clinic Services (Recodified)
- 140.200 Payment for Hospital Services During Fiscal Year 1982 (Recodified)
- 140.201 Payment for Hospital Services After June 30, 1982 (Repealed)
- 140.202 Payment for Hospital Services During Fiscal Year 1983 (Recodified)
- 140.203 Limits on Length of Stay by Diagnosis (Recodified)
- 140.300 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Recodified)
- 140.350 Copayments (Recodified)
- 140.360 Payment Methodology (Recodified)
- 140.361 Non-Participating Hospitals (Recodified)
- 140.362 Pre July 1, 1989 Services (Recodified)
- 140.363 Post June 30, 1989 Services (Recodified)
- 140.364 Prepayment Review (Recodified)
- 140.365 Base Year Costs (Recodified)
- 140.366 Restructuring Adjustment (Recodified)
- 140.367 Inflation Adjustment (Recodified)
- 140.368 Volume Adjustment (Repealed)
- 140.369 Groupings (Recodified)
- 140.370 Rate Calculation (Recodified)
- 140.371 Payment (Recodified)
- 140.372 Review Procedure (Recodified)
- 140.373 Utilization (Repealed)
- 140.374 Alternatives (Recodified)
- 140.375 Exemptions (Recodified)
- 140.376 Utilization, Case-Mix and Discretionary Funds (Repealed)
- 140.390 Subacute Alcoholism and Substance Abuse Services (Recodified)
- 140.391 Definitions (Recodified)
- 140.392 Types of Subacute Alcoholism and Substance Abuse Services (Recodified)
- 140.394 Payment for Subacute Alcoholism and Substance Abuse Services (Recodified)

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- 140.396 Rate Appeals for Subacute Alcoholism and Substance Abuse Services (Recodified)
140.398 Hearings (Recodified)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section

- 140.400 Payment to Practitioners
140.402 Copayments for Noninstitutional Medical Services
140.405 SeniorCare Pharmaceutical Benefit
140.410 Physicians' Services
140.411 Covered Services By Physicians
140.412 Services Not Covered By Physicians
140.413 Limitation on Physician Services
140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items - Physicians
140.416 Optometric Services and Materials
140.417 Limitations on Optometric Services
140.418 Department of Corrections Laboratory
140.420 Dental Services
140.421 Limitations on Dental Services
140.422 Requirements for Prescriptions and Dispensing Items of Pharmacy Items - Dentists
140.425 Podiatry Services
140.426 Limitations on Podiatry Services
140.427 Requirement for Prescriptions and Dispensing of Pharmacy Items - Podiatry
140.428 Chiropractic Services
140.429 Limitations on Chiropractic Services (Repealed)
140.430 Independent Clinical Laboratory Services
140.431 Services Not Covered by Independent Clinical Laboratories
140.432 Limitations on Independent Clinical Laboratory Services
140.433 Payment for Clinical Laboratory Services
140.434 Record Requirements for Independent Clinical Laboratories
140.435 Advanced Practice Nurse Services
140.436 Limitations on Advanced Practice Nurse Services
140.438 Imaging Centers
140.440 Pharmacy Services
140.441 Pharmacy Services Not Covered
140.442 Prior Approval of Prescriptions
140.443 Filling of Prescriptions
140.444 Compounded Prescriptions
140.445 Legend Prescription Items (Not Compounded)
140.446 Over-the-Counter Items

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- 140.447 Reimbursement
- 140.448 Returned Pharmacy Items
- 140.449 Payment of Pharmacy Items
- 140.450 Record Requirements for Pharmacies
- 140.451 Prospective Drug Review and Patient Counseling
- 140.452 Mental Health Clinic Services
- 140.453 Definitions
- 140.454 Types of Mental Health Clinic Services
- 140.455 Payment for Mental Health Clinic Services
- 140.456 Hearings
- 140.457 Therapy Services
- 140.458 Prior Approval for Therapy Services
- 140.459 Payment for Therapy Services
- 140.460 Clinic Services
- 140.461 Clinic Participation, Data and Certification Requirements
- 140.462 Covered Services in Clinics
- 140.463 Clinic Service Payment
- 140.464 Healthy Moms/Healthy Kids Managed Care Clinics (Repealed)
- 140.465 Speech and Hearing Clinics (Repealed)
- 140.466 Rural Health Clinics (Repealed)
- 140.467 Independent Clinics
- 140.469 Hospice
- 140.470 Home Health Services
- 140.471 Home Health Covered Services
- 140.472 Types of Home Health Services
- 140.473 Prior Approval for Home Health Services
- 140.474 Payment for Home Health Services
- 140.475 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
- 140.476 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices for Which Payment Will Not Be Made
- 140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices
- 140.478 Prior Approval for Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
- 140.479 Limitations, Medical Supplies
- 140.480 Equipment Rental Limitations
- 140.481 Payment for Medical Equipment, Supplies, Prosthetic Devices and Hearing Aids
- 140.482 Family Planning Services
- 140.483 Limitations on Family Planning Services
- 140.484 Payment for Family Planning Services

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- 140.485 Healthy Kids Program
- 140.486 Limitations on Medichek Services (Repealed)
- 140.487 Healthy Kids Program Timeliness Standards
- 140.488 Periodicity Schedules, Immunizations and Diagnostic Laboratory Procedures
- 140.490 Medical Transportation
- 140.491 Limitations on Medical Transportation
- 140.492 Payment for Medical Transportation
- 140.493 Payment for Helicopter Transportation
- 140.494 Record Requirements for Medical Transportation Services
- 140.495 Psychological Services
- 140.496 Payment for Psychological Services
- 140.497 Hearing Aids

SUBPART E: GROUP CARE

Section

- 140.500 Long Term Care Services
- 140.502 Cessation of Payment at Federal Direction
- 140.503 Cessation of Payment for Improper Level of Care
- 140.504 Cessation of Payment Because of Termination of Facility
- 140.505 Informal Hearing Process for Denial of Payment for New ICF/MR
- 140.506 Provider Voluntary Withdrawal
- 140.507 Continuation of Provider Agreement
- 140.510 Determination of Need for Group Care
- 140.511 Long Term Care Services Covered By Department Payment
- 140.512 Utilization Control
- 140.513 Notification of Change in Resident Status
- 140.514 Certifications and Recertifications of Care
- 140.515 Management of Recipient Funds--Personal Allowance Funds
- 140.516 Recipient Management of Funds
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- 140.526 Quality Incentive Standards and Criteria for the Quality Incentive Program (QUIP) (Repealed)
- 140.527 Quality Incentive Survey (Repealed)
- 140.528 Payment of Quality Incentive (Repealed)
- 140.529 Reviews (Repealed)
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- 140.534 Ownership Costs
- 140.535 Costs for Interest, Taxes and Rent
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SUBPART F: FEDERAL CLAIMING FOR STATE AND LOCAL GOVERNMENTAL ENTITIES

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- 140.865 Sponsor Qualifications (Repealed)
- 140.870 Sponsor Responsibilities (Repealed)
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- 140.885 Provider Responsibilities (Repealed)
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- 140.901 Functional Areas of Needs (Recodified)
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- 140.920 General Description
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- 140.958 Admitting and Clinical Privileges (Recodified)
- 140.960 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Recodified)
- 140.962 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Recodified)
- 140.964 Contract Monitoring (Recodified)
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- 140.970 Termination of ICARE Contracts (Recodified)
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- 140.980 Elimination Of Aid To The Medically Indigent (AMI) Program (Emergency Expired)
- 140.982 Elimination Of Hospital Services For Persons Age Eighteen (18) And Older And Persons Married And Living With Spouse, Regardless Of Age (Emergency Expired)

- 140.TABLE A Medichex Recommended Screening Procedures (Repealed)
- 140.TABLE B Geographic Areas
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- 140.TABLE E Time Limits for Processing of Prior Approval Requests
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- 140.TABLE G Travel Distance Standards
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- 140.TABLE J HSA Grouping (Repealed)
- 140.TABLE K Services Qualifying for 10% Add-On (Repealed)

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- 140.TABLE L Services Qualifying for 10% Add-On to Surgical Incentive Add-On (Repealed)
- 140.TABLE M Enhanced Rates for Maternal and Child Health Provider Services

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

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000,

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effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg. 7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency

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amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Re. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7025, effective April 24, 1989; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective

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January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; Section 140.569 withdrawn at 15 Ill. Reg. 1174; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; emergency amendment suspended effective October 12, 1993; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28,

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1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill.

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Reg.13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25 Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 1, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003.

SUBPART A: GENERAL PROVISIONS

Section 140.3 Covered Services Under Medical Assistance Programs

- a) As described in this Section, medical services shall be covered for:
 - 1) recipients of financial assistance under the AABD (Aid to the Aged, Blind or Disabled), TANF (Temporary Assistance to Needy Families), or Refugee/Entrant/Repatriate programs;
 - 2) recipients of medical assistance only under the AABD program (AABD-MANG);

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- 3) recipients of medical assistance only under the TANF program (TANF-MANG);
 - 4) individuals under age 18 not eligible for TANF (see Section 140.7), pregnant women who would be eligible if the child were born and pregnant women and children under age eight who do not qualify as mandatory categorically needy (see Section 140.9);
 - 5) disabled persons under age 21 who may qualify for Medicaid and in-home care (Model Waiver); ~~and~~
 - 6) recipients eligible under the State Transitional Assistance Program who are determined by the Department to be disabled; ~~and-~~
 - 7) [Individuals 19 years of age or older eligible under the KidCare Parent Coverage Waiver as described at 89 Ill. Adm. Code 120.32 except for:](#)
 - A) [Services provided only through a waiver approved under section 1915\(c\) of the Social Security Act; and](#)
 - B) [Termination of pregnancy.](#)
- b) The following medical services shall be covered for recipients under age 21 who are included under subsection (a) above:
- 1) Inpatient hospital services;
 - 2) Hospital outpatient and clinic services;
 - 3) Hospital emergency room visits. The visit must be for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries which might result in disability or death if there is not immediate treatment;
 - 4) Encounter rate clinic visits;
 - 5) Physician services;
 - 6) Pharmacy services;
 - 7) Home health agency visits;
 - 8) Laboratory and x-ray services;
 - 9) Group care services;
 - 10) Family planning services and supplies;
 - 11) Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
 - 12) Transportation to secure medical services;
 - 13) Medichex (EPSDT) services;
 - 14) Dental services;
 - 15) Chiropractic services;
 - 16) Podiatric services;
 - 17) Optical services and supplies;

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- 18) Subacute alcoholism and substance abuse services pursuant to Sections 140.390 through 140.396; and
 - 19) Hospice services.
- c) The following medical services shall be covered for recipients age 21 or over who are included under subsection (a) above:
- 1) Inpatient hospital services;
 - 2) Hospital outpatient and clinic services;
 - 3) Hospital emergency room visits. The visit must be for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries which might result in disability or death if there is not immediate treatment;
 - 4) Encounter rate clinic visits;
 - 5) Physician services;
 - 6) Pharmacy services;
 - 7) Home health agency visits;
 - 8) Laboratory and x-ray services;
 - 9) Group care services;
 - 10) Family planning services and supplies;
 - 11) Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
 - 12) Transportation to secure medical services;
 - 13) Medichex (EPSDT) services;
 - 14) Subacute alcoholism and substance abuse services pursuant to Sections 140.390 through 140.396;
 - 15) Hospice services;
- Dental services;
Chiropractic services;
Podiatric services; and
Optical services and supplies.

(Source: Amended at 27 Ill. Reg. 4364, effective February 24, 2003)

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section 140.21 [Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits](#) ~~Covered Medicaid Services for Qualified Medicare Beneficiaries (QMBs)~~

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- a) In order to be qualified to receive reimbursement for services provided to QMB (Qualified Medicare Beneficiary) eligible medical assistance recipients, QMB eligible only recipients ~~clients~~ (see 89 Ill. Adm. Code 120.72), or individuals who are entitled to Medicare Part A or Part B and are eligible for some form of Medicaid benefits, providers must be enrolled in the Medical Assistance Program. Providers must also accept assignment of Medicare benefits for QMB eligible medical assistance recipients and individuals who are entitled to Medicare Part A or Part B and are eligible for some form of Medicaid benefits, when payment for services to such persons is sought from the Department.
- b) For Medicaid covered services, the Department will reimburse qualified providers who render services to QMB eligible medical assistance recipients, QMB eligible only recipients and individuals who are entitled to Medicare Part A or Part B and are eligible for some form of Medicaid benefits ~~QMBs~~ in accordance with Department standards for the service(s) provided, with the following exception: for drugs and medical supplies provided by a pharmacy or Durable Medical Equipment (DME) provider, and reimbursed by Medicare, the Department=s liability for deductible and coinsurance amounts shall be at the full Medicare rate. For individuals enrolled in the Senior Care Program, the provisions in this subsection (b) will apply to services provided on or after October 16, 2002. For services approved by Medicare but not covered by Medicaid, the Department will reimburse qualified providers who render services to QMBs at the full Medicare deductible and coinsurance rate.
- c) For services approved by Medicare but not covered by Medicaid, the maximum allowable rate payable to qualified providers who render services to QMB eligible medical assistance recipients and recipients who are QMB eligible only is 80 percent of the full Medicare rate when determining the Department=s liability for deductible and coinsurance amounts.
- d)e) Licensed and Medicare certified nursing facilities that enroll for the sole purpose of receiving payment for services to QMB eligible only residents of the facility, then disenroll, are not subject to the provisions found in Section 140.506 governing voluntary withdrawal from the Medical Assistance Program.

(Source: Amended at 27 Ill. Reg. 4364, effective February 24, 2003)

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- 1) Heading of the Part: Hospital Services
- 2) Code Citation: 89 Ill. Adm. Code 148
- 3) Section Numbers:

148.105	New Section
148.115	New Section
148.295	Amendment
148.310	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Amendments: February 24, 2003
- 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:
August 30, 2002 (26 Ill. Reg. 13046)
- 10) Has JCAR issued a Statement of Objections to these rules? No
- 11) Differences Between Proposal and Final Version:
Section 148.295
In subsection (c)(2)(B)(viii), "\$93" has been changed to "\$76".
In subsection (c)(2)(B)(ix), "\$41.00" has been changed to "\$110.00".
In subsection (c)(2)(C)(ii), "\$206.00" has been changed to "\$262.00".
No other substantive changes have been made.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will these amendments replace emergency amendments currently in effect? Yes
- 14) Are there any other amendments pending on this Part? Yes

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<u>Sections</u>	<u>Proposed Action</u>	<u>Illinois Register Citation</u>
148.126	Amendment	December 2, 2002 (26 Ill. Reg. 17143)
148.140	Amendment	January 10, 2003 (26 Ill. Reg. 484)

15) Summary and Purpose of Amendments:

These changes on fiscal year 2003 budget implementation affect specified inpatient and outpatient services. The amendments pertain to Hospital Adjustment Payments (CHAP) and add two new programs for Psychiatric Adjustment Payments and Rural Adjustment Payments. Additional amendments provide appeal procedures concerning the new payment programs.

Under CHAP, some Direct Hospital Adjustments (DHA) rate levels are being increased to provide additional funding to high volume Medicaid providers in order to ensure access to quality healthcare for the Department's medical assistance clients. The new Psychiatric Adjustment Payments program is designed to ensure access to essential psychiatric services, particularly for clients who live in downstate Illinois. The new Rural Adjustment Payments program is intended to add a cost-based reimbursement system for hospitals deemed by the Illinois Department of Public Health to be a critical access hospital or a necessary provider. Under Medicare, such hospitals are reimbursed on a cost basis.

These changes will result in the following spending increases:

Psychiatric Adjustment Payments (Section 148.105) - \$3.1 million
Rural Adjustment Payments (Section 148.115) - \$7.0 million
CHAP (Section 148.295) - \$7.8 million

16) Information and questions regarding these adopted amendments shall be directed 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 full text of the adopted amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMSPART 148
HOSPITAL SERVICES

SUBPART A: GENERAL PROVISIONS

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

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section	
148.80	Organ Transplants Services Covered Under Medicaid (Repealed)
148.82	Organ Transplant Services
148.90	Heart Transplants (Repealed)
148.100	Liver Transplants (Repealed)
148.105	Psychiatric Adjustment Payments
148.110	Bone Marrow Transplants (Repealed)
148.115	Rural Adjustment Payments
148.120	Disproportionate Share Hospital (DSH) Adjustments
148.126	Safety Net Adjustment Payments
EMERGENCY	
148.130	Outlier Adjustments for Exceptionally Costly Stays
148.140	Hospital Outpatient and Clinic Services
EMERGENCY	
148.150	Public Law 103-66 Requirements
148.160	Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million
148.170	Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act

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

SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

Section

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- 148.500 Definitions
- 148.510 Reimbursement

SUBPART D: STATE CHRONIC RENAL DISEASE PROGRAM

Section

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

- 148.TABLE A Renal Participation Fee Worksheet
- 148.TABLE B Bureau of Labor Statistics Equivalence
- 148.TABLE C List of Metropolitan Counties by SMSA Definition

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

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648,

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effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency expired July 29, 1995; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective November 28, 1995; amended at 20 Ill. Reg. 872, effective December 29, 1995; amended at 20 Ill. Reg. 7912, effective May 31, 1996; emergency amendment at 20 Ill. Reg. 9281, effective July 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 12510, effective September 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15722, effective November 27, 1996; amended at 21 Ill. Reg. 607, effective January 2, 1997; amended at 21 Ill. Reg. 8386, effective June 23, 1997; emergency amendment at 21 Ill. Reg. 9552, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9822, effective July 2, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 10147, effective August 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13349, effective September 23, 1997; emergency amendment at 21 Ill. Reg. 13675, effective September 27, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16161, effective November 26, 1997; amended at 22 Ill. Reg. 1408, effective December 29, 1997; amended at 22 Ill. Reg. 3083, effective January 26, 1998; amended at 22 Ill. Reg. 11514, effective June 22, 1998; emergency amendment at 22 Ill. Reg. 13070, effective July 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 15027, effective August 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16273, effective August 28, 1998; amended at 22 Ill. Reg. 21490, effective November 25, 1998; amended at 23 Ill. Reg. 5784, effective April 30, 1999; amended at 23 Ill. Reg. 7115, effective June 1, 1999; amended at 23 Ill. Reg. 7908, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8213, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12772, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13621, effective November 1, 1999; amended at 24 Ill. Reg. 2400, effective February 1, 2000; amended at 24 Ill. Reg. 3845, effective February 25, 2000; emergency amendment at 24 Ill. Reg. 10386, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11846, effective August 1, 2000; amended at 24 Ill. Reg. 16067, effective October 16, 2000; amended at 24 Ill. Reg. 17146, effective November 1, 2000; amended at 24 Ill. Reg. 18293, effective December 1, 2000; amended at 25 Ill. Reg. 5359, effective April 1, 2001; emergency amendment at 25 Ill. Reg. 5432, effective April 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6959, effective June 1, 2001; emergency amendment at 25 Ill. Reg. 9974, effective July 23, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 10513, effective August 2, 2001; emergency amendment at 25 Ill. Reg. 12870, effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002; amended at 25 Ill. Reg. 16087, effective December 1, 2001; emergency amendment at 26 Ill. Reg. 536, effective December 31, 2001, for a maximum of 150 days; emergency amendment at

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26 Ill. Reg. 680, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 4825, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 4953, effective March 18, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 7340, effective April 30, 2002, for a maximum of 150 days; emergency repealed at 26 Ill. Reg. 7786, effective July 1, 2002; amended at 26 Ill. Reg. 8395, effective May 28, 2002; emergency amendment at 26 Ill. Reg. 11040, effective July 1, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16612, effective October 22, 2002; amended at 26 Ill. Reg. 12322, effective July 26, 2002; amended at 26 Ill. Reg. 13661, effective September 3, 2002; amended at 26 Ill. Reg. 14808, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 14887, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17775, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 580, effective January 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 866, effective January 1, 2003, for a maximum of 150 days; amendment at 27 Ill. Reg. 4386, effective February 24, 2003.

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.105 Psychiatric Adjustment Paymentsa) Qualifying Criteria

Psychiatric Adjustment Payments shall be made to a qualifying hospital, as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria as of July 1, 2002:

- 1) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; and has a MIUR as described in subsection (e)(5) of this Section that is greater than 60 percent.
- 2) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) that is greater than 20 percent; has greater than 325 total licensed beds as described in subsection (e)(2) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 50 percent.

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- 3) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 15 percent; has greater than 500 total licensed beds as described in subsection (e)(2) of this Section; has a psychiatric occupancy rate as described in subsection (e)(4) of this Section that is greater than 35 percent; and has total licensed psychiatric beds described in subsection (e)(3) of this Section that is greater than 50.
- 4) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 19 percent; has less than 275 total licensed beds as described in subsection (e)(2) of this Section; has fewer than 1,000 total psychiatric care days as described in subsection (e)(8) of this Section; has 40 or fewer total licensed psychiatric beds as described in subsection (e)(3) of this Section; has greater than 6,000 total days as described in subsection (e)(9) of this Section.
- b) The following five classes of hospitals are ineligible for Psychiatric Adjustment Payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4) of this Section:
 - 1) Hospitals located outside of Illinois.
 - 2) Hospitals located inside HSA 6.
 - 3) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(c)(1).
 - 4) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(c)(4).
 - 5) A children's hospital, as described in 89 Ill. Adm. Code 149.50(c)(3).
- c) Psychiatric Adjustment Payment Rates
 - 1) For a hospital qualifying under subsection (a)(1) of this Section, the rate is \$63.00.
 - 2) For a hospital qualifying under subsection (a)(2) of this Section that:
 - A) Has less than 10,000 total days, the rate is \$78.00.
 - B) Has equal to or greater than 10,000 total days, the rate is \$125.00.
 - 3) For a hospital qualifying under subsection (a)(3) of this Section, the rate is \$21.00.

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- 4) For a hospital qualifying under subsection (a)(4) of this Section, the rate is \$38.00.
- d) Payment to a Qualifying Hospital
- 1) The total annual adjustment amount to a qualifying hospital shall be the product of the appropriate psychiatric adjustment payment rate, as described in subsection (c) of this Section, multiplied by total days as described in subsection (e)(9) of this Section.
 - 2) The total annual adjustment amount shall be paid to the hospital during the Psychiatric Adjustment Payment period in installments on, at least, a quarterly basis.
- e) Definitions
- 1) “HSA” means Health Service Area, as defined by the Illinois Department of Public Health.
 - 2) “Total licensed beds” means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled “Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois”.
 - 3) “Licensed psychiatric beds” means, for a given hospital, the number of psychiatric licensed beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled “Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois”.
 - 4) “Psychiatric occupancy rate” means, for a given hospital, the psychiatric hospital occupancy rate as listed in the July 25, 2001, Illinois Department of Public Health report entitled “Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois”.
 - 5) “MIUR” for a given hospital, has the meaning as defined in Section 148.120(k)(5), and shall be determined in accordance with Sections 148.120(c) and (f). For purposes of this rulemaking, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment Payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for Psychiatric Adjustment Payments in the Psychiatric Adjustment Payment Period.
 - 6) “Psychiatric Adjustment Payment base year” means the 12-month period beginning on July 1, 2000, and ending on June 30, 2001.
 - 7) “Psychiatric Adjustment Payment period” means, beginning October 1, 2002, the nine month period beginning October 1 and ending June 30 of

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- the following year, and beginning July 1, 2003, the 12 month period beginning July 1 of the year and ending June 30 of the following year.
- 8) “Total psychiatric care days” means, for a given hospital, the sum of days of inpatient psychiatric care, as defined in Section 148.40(a), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department’s claims data for admissions occurring in the Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.
- 9) “Total days” means, for a given hospital, the sum of days of inpatient hospital services provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department’s claims data for admissions occurring in the Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.
- 10) "Psychiatric care average length of stay" means the quotient of the fraction, the numerator of which is the number of psychiatric care days in the Psychiatric Adjustment Payment base year, the denominator of which is the number of admissions in the Psychiatric Adjustment Payment base year.

(Source: Added at 27 Ill. Reg. 4386, effective February 24, 2003)

Section 148.115 Rural Adjustment Payments

- a) Qualifying Criteria
Rural Adjustment Payments shall be made to all qualifying general acute care hospitals that are designated as a Critical Access Hospital or a Necessary Provider, as designated by the Illinois Department of Public Health, in accordance with 42 CFR 485, Subpart F (2001), as of the first day of July in the Rural Adjustment Payment rate period.
- b) Rural Adjustment Rates
- 1) Inpatient Component
For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment inpatient component shall be calculated as follows:
- A) Total inpatient payments, as described in subsection (d)(2) of this Section, shall be divided by the total inpatient days, as described in

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- subsection (d)(4) of this Section, to derive an inpatient payment per day.
- B) Total inpatient charges, associated with inpatient days as described in subsection (d)(4) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total inpatient cost.
 - C) Total inpatient costs, as defined in subsection (b)(1)(B) of this Section, are divided by the total inpatient days, as described in subsection (d)(4) of this Section, to derive an inpatient cost per day.
 - D) Inpatient payment per day, as defined in subsection (b)(1)(A) of this Section, shall be subtracted from the inpatient cost per day, as described in subsection (b)(1)(C) of this Section, to derive an inpatient cost coverage deficit per day. The minimum result shall be no lower than zero.
 - E) Inpatient cost coverage deficit per day, as described in subsection (b)(1)(D) of this Section, shall be multiplied by the total inpatient days, as described in subsection (d)(4) of this Section, to derive a total hospital specific inpatient cost coverage deficit.
 - F) The inpatient cost deficits, as described in subsection (b)(1)(E) of this Section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year inpatient cost deficit.
- 2) Outpatient Component
For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment outpatient component shall be calculated as follows:
- A) Total outpatient payments, as defined in subsection (d)(3) of this Section, shall be divided by the total outpatient services, as described in subsection (d)(5) of this Section, to derive an outpatient payment per service unit.
 - B) Total outpatient charges, associated with outpatient services, as defined in subsection (d)(5) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total outpatient cost.
 - C) Total outpatient costs, as defined in subsection (b)(2)(B) of this Section, are divided by the total outpatient services, as described in subsection (d)(5) of this Section, to derive an outpatient cost per service unit.

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- D) Outpatient payment per service unit, as defined in subsection (b)(2)(A) of this Section, shall be subtracted from the outpatient cost per service unit, as described in subsection (b)(2)(C) of this Section, to derive an outpatient cost coverage deficit per service unit. The minimum result shall be no lower than zero.
 - E) Outpatient cost coverage deficit per service unit, as described in subsection (b)(2)(D) of this Section, shall be multiplied by the total outpatient services, as described in subsection (d)(5) of this Section, to derive a total hospital specific outpatient cost coverage deficit.
 - F) The outpatient cost coverage deficits, as described in subsection (b)(2)(e) of this Section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year outpatient cost deficit.
- 3) Payment Methodology
A \$7 million total pool shall be allocated to the program, and proportioned between inpatient services and outpatient services as follows:
- A) The total inpatient cost coverage deficit, as described in subsection (b)(1)(F) of this Section, is added to the total outpatient cost coverage deficit, as described in subsection (b)(2)(F) of this Section, to derive a total Rural Adjustment Payment base year deficit.
 - B) The inpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total inpatient cost deficit, as described in subsection (b)(1)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.
 - C) The outpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total outpatient cost deficit, as described in subsection (b)(2)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.
 - D) An inpatient pool allocation shall be the product of the inpatient pool allocation percentage, as described in subsection (b)(3)(B) of this Section, multiplied by the \$7 million pool, as described in subsection (b)(3) of this Section.
 - E) The outpatient pool allocation shall be the product of the outpatient pool allocation percentage, as described in subsection (b)(3)(C) of

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- this Section, multiplied by the \$7 million pool, as described in subsection (b)(3) of this Section.
- F) An inpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the inpatient pool allocation, as described in subsection (b)(3)(D) of this Section, the denominator of which shall be the total inpatient cost deficit as described in subsection (b)(1)(F) of this Section.
- G) An outpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the outpatient pool allocation, as described in subsection (b)(3)(E) of this Section, the denominator of which shall be the total outpatient cost deficit as described in subsection (b)(2)(F) of this Section.
- H) The hospital specific inpatient cost coverage adjustment amount shall be the product of the inpatient residual cost coverage factor, as described in subsection (b)(3)(F) of this Section, multiplied by the hospital specific inpatient cost coverage deficit, as described in subsection (b)(1)(E) of this Section.
- I) The hospital specific outpatient cost coverage adjustment amount shall be the product of the outpatient residual cost coverage factor, as described in subsection (b)(3)(G) of this Section, multiplied by the hospital specific outpatient cost coverage deficit, as described in subsection (b)(2)(E) of this Section.
- c) Payment to a Qualifying Hospital
- 1) The total annual adjustment amount to a qualified hospital shall be the sum of the hospital specific inpatient cost coverage adjustment amount, as described in subsection (b)(3)(H) of this Section, plus the hospital specific outpatient cost coverage adjustment amount, as described in subsection (b)(3)(I) of this Section.
- 2) The total annual adjustment amount shall be paid to the hospital during the Rural Adjustment Payment rate period, as described in subsection (d)(7) of this Section, on at least a quarterly basis.
- d) Definitions
- 1) "Hospital cost to charge ratio" means the quotient of the fraction, the numerator of which is the cost as reported on Form CMS 2552, worksheet C, Part 1, column 1, row 101, the denominator of which is the charges as reported on Form HCFA 2552, worksheet C, Part 1, column 8, row 101. The base year for State Fiscal Year (SFY) 2003 shall be the hospital's fiscal year 1999 Medicare cost report, and, for SFY 2004, the hospital's

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fiscal year 2000 cost report shall be utilized. The base year for any SFY shall be determined in this manner.

- 2) "Inpatient payments" shall mean all payments associated with total days provided, as described in subsection (d)(4) of this Section, and all quarterly adjustment payments paid, as described throughout Part 148.
- 3) "Outpatient payments" shall mean all payments associated with total outpatient services provided, as described in subsection (d)(5) of this Section, and all quarterly adjustment payments paid, as described in this Part.
- 4) "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.
- 5) "Total outpatient services" means the number of outpatient services provided during the Rural Adjustment Payment base year, to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for services occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.
- 6) "Rural Adjustment Payment base year" means, for the Rural Adjustment Payment rate period beginning October 1, 2002, SFY 2001; for the Rural Adjustment Payment rate period beginning July 1, 2003, SFY 2002. The Rural Adjustment Payment base year for subsequent rate periods shall be determined in this manner.
- 7) "Rural Adjustment Payment rate period" means, beginning October 1, 2002, the nine month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12 month period beginning July 1 of that year and ending June 30 of the following year.

(Source: Added at 27 Ill. Reg. 4386, effective February 24, 2003)

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Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25 (b)(1)(A), unless otherwise noted in this Section, and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25 (b)(1)(B), for inpatient admissions occurring on or after July 1, 1998, in accordance with this Section. ~~The provisions described in this Section will be effective through June 30, 2002.~~

a) Trauma Center Adjustments (TCA)

The Department shall make a ~~trauma center adjustment (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 ~~(TCA)~~.

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 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 ~~(TCA)~~. 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 ~~(TCA)~~. 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

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\$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 (~~42 CFR 5~~) 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:
- 1) Treatment Component. All hospitals defined in subsection (b) of this Section shall receive \$4,215.00 ~~\$3,886~~ 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 ~~\$211,450~~ 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 ~~\$486,335~~ 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 (~~42 CFR 5~~) on July 1, 1999, shall receive \$276.00 ~~\$254~~ per Medicaid Level I rehabilitation inpatient day in the CHAP base period.
- c) Direct Hospital Adjustment (DHA) Criteria
- 1) Qualifying Criteria

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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 Il. 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 Section 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 subsections (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~~

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- ~~hospitals that had an MIUR greater than 20.25 percent on July 1, 1999, and provided more than 20,000 Total days:~~
- ~~G)~~ 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), (E) or (F) of this Section, all other hospitals that had an MIUR greater than 50 percent on July 1, 1999, and provided more than 10,000 Total days:
- ~~FH)~~ 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), ~~(F) or (G)~~ 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.
- 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 ~~\$63~~ per day for hospitals that do not provide obstetrical care and \$105.00 ~~\$97~~ 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 ~~\$97~~ per day for hospitals that do not provide obstetrical care and \$142.00 ~~\$131~~ 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 ~~\$114~~ per day for hospitals that do not provide obstetrical care and \$160.00 ~~\$148~~ per day for hospitals that do provide obstetrical care.

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- iv) Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive ~~\$131~~ \$142.00 per day for hospitals that do not provide obstetrical care and ~~\$165~~ \$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 ~~\$292~~ \$330.00 per day.
 - iii) Hospitals with more than 80,000 Total days will have their rate increased by an additional ~~\$434~~ \$423.00 per day.
 - iv) Hospitals with more than 4,500 Obstetrical days will have their rate increased by ~~\$93~~ \$101.00 per day.
 - v) Hospitals with more than 5,500 Obstetrical days will have their rate increased by an additional ~~\$202~~ \$194.00 per day.
 - vi) Hospitals with an MIUR ~~rate~~ greater than 74 percent will have their rate increased by ~~\$135~~ \$147.00 per day.
 - vii) Hospitals with an average length of stay less than 3.9 days will have their rate increased by ~~\$38~~ \$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 ~~\$76~~ \$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 ~~\$38~~ \$110.00 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 ~~\$186~~ \$202.00 per day.
 - xi) Hospitals receiving payments under subsection (c)(2)(A)(iv) of this Section that have ~~a Medicaid~~ an MIUR

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- ~~inpatient utilization rate~~ greater than 70 percent and have more than 20,000 days will have their rate increased by ~~\$11.00~~ \$4 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 ~~\$303.00~~ \$279 per day.
 - ii) Qualifying hospitals with more than 1,500 Obstetrical days will have their rate increased by ~~\$262.00~~ \$190 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~~ \$25 per day.
 - ii) Hospitals located in Illinois and outside of HSA 6; that have an MIUR ~~a Medicaid inpatient utilization rate~~ greater than 60 percent; will have their rate increased by ~~\$55.00~~ \$51 per day.
 - iii) Hospitals located in Illinois and inside HSA 6; that have an MIUR ~~a Medicaid inpatient utilization rate~~ greater than 80 percent; will have their rate increased by ~~\$403.00~~ \$364 per day.
 - iv) Hospitals that are not located in Illinois that have an MIUR ~~a Medicaid inpatient utilization rate~~ greater than 45 percent will have their rate increased by ~~\$32.00~~ \$30 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 ~~\$248.00~~ \$228 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~~ \$38 per day.
 - ii) Hospitals with an MIUR between 18 percent and 19.75 percent will have their rate increased by an additional ~~\$14.00~~ \$13 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~~ \$31 per day.

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- 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~~ ~~\$83~~ per day.
 - F) Hospitals qualifying under subsection (c)(1)(E) of this Section will receive ~~\$188.00~~ ~~\$173~~ per day.
 - ~~G) Hospitals qualifying under subsection (c)(1)(F) of this Section will receive a rate of \$135 per day.~~
 - ~~H) Hospitals qualifying under subsection (c)(1)(G) of this Section will receive a rate of \$38 per day.~~
 - ~~G)H~~ Hospitals qualifying under subsection (c)(1)(~~F~~)(~~H~~) of this Section will receive a rate of ~~\$55.00~~ ~~\$51~~ per day.
 - ~~H)H~~ Hospitals that qualify under subsection (c)(1)(A)(iii) of this Section will have their rates multiplied by a factor of two.
- 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 2003, total payments will equal the methodologies described in subsection (c)(2) of this Section. For the period October 1, 2002, to June 30, 2003, payment will equal the State fiscal year 2003 amount less the amount the hospital received under DHA for the quarter ended September 30, 2002.
 - ii) For CHAP rate periods occurring after State fiscal year 2003, total payments will equal the methodologies described above.
- d) Rural Critical Hospital Adjustment Payments (RCHAP)
- ~~Rural Critical Hospital Adjustment Payments (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~~ ~~\$338,320~~ per year. The Department shall also make an RCHAP ~~adjustment payment~~ to hospitals qualifying under this subsection at a rate that is the greater of:
- 1) the product of ~~\$1,367.00~~ ~~\$1,260~~ multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or

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- 2) the product of ~~\$138.00~~ ~~\$127~~ multiplied by the number of RCHAP General Care Admissions in the CHAP base period.
- e) Total CHAP ~~Payment~~ Adjustments
~~For the remainder of the CHAP rate period occurring in State fiscal year 2002, Each each~~ eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts for the programs described in subsections (a), (b), (c) and (d) of this Section, ~~shall equal the result of the following calculation:~~
- ~~1) The total payments resulting from payment methodologies in effect on January 1, 2002, will be reduced by the total payments calculated from the payment methodologies that were in effect on December 31, 2001.~~
 - ~~2) The difference from subsection (e)(1) of this Section will be divided by two and added to the total payments calculated from the payment methodologies that were in effect on December 31, 2001.~~
 - ~~3) The result of the calculation in subsection (e)(2) of this Section will be reduced by the actual payments each hospital already received for the period beginning July 1, 2001, and ending December 31, 2001, to produce the total payments for the remainder of State fiscal year 2002.~~
 - 4) 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) "CHAP base period" means State Fiscal Year 1994 for CHAP ~~payments~~ calculated for the July 1, 1995, CHAP rate period; State Fiscal Year 1995 for CHAP ~~payments~~ calculated for the July 1, 1996, CHAP rate period; etc.
 - 2) "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.
 - 3) "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

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the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120(k)(6), as of July 1, 1999.

- 4) "Medicaid general care admission" means hospital inpatient admissions ~~that~~ ~~which~~ 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.
- 5) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions ~~that~~ ~~which~~ were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.
- 6) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.
- 7) "Medicaid obstetrical care admission" means hospital inpatient admissions ~~that~~ ~~which~~ 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.
- 8) "Medicaid trauma admission" means those claims billed as admissions ~~that~~ ~~which~~ 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 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99,

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852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.

- 9) "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.
- 10) "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.
- 11) "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.
- 12) "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.
- 13) "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.
- 14) "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: Amendment at 27 Ill. Reg. 4386, effective February 24, 2003)

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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.
 - 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 which~~ have been mandated in order to meet State, federal or local health and safety standards, and ~~that which~~ 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) DSH Determination Reviews
 - 1) Hospitals shall be notified of their qualification for DSH payment adjustments and shall have an opportunity to request a review of the DSH 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 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 determination reviews shall be limited to the following:

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- A) DSH Determination Criteria. The criteria for DSH determination shall be in accordance with Section 148.120. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.
- B) Medicaid Inpatient Utilization Rates.
- i) Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)(5). 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)(5), 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 determination.
- C) Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act and Section 148.120(a)(2) and (d). 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 148.120(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 (~~Code~~ Section 148.120(a)(3) and 77 Ill. Adm. Code 1100) based upon the methodologies utilized by, and the most current information available to, the

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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 148.120(a)(4), (k)(4), (k)(6) and (k)(7). Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with [Section 148.12 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 which](#) 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 which](#) 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
 - 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 of](#) 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

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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~~ ~~which~~ 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~~ ~~which~~ 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.
 - 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

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Medicaid inpatient days were calculated in accordance with [Section 148.120 State regulations](#). 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](#) ~~it is believed~~ 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.

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](#) ~~it is believed~~ 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.

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- i) Critical Hospital Adjustment Payment (CHAP) Reviews
 - 1) The Department shall make CHAP **payments** 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 ~~it is~~ **believed** 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 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,

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- 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 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](#) ~~it is believed~~ 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 Payments. 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](#) ~~it is believed~~ 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 148.297 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 Payments. 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 it is believed that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification under Section 148.298 and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.m) [Safety Net Adjustment Payment Reviews. The Department shall make Safety Net Adjustment Payments in accordance with Section 148.126. Hospitals shall be notified in writing of the results of the Safety Net Adjustment Payment determination and calculation, and shall have the right to appeal the Safety Net Adjustment Payment calculation or their ineligibility for Safety Net Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Safety Net Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Safety Net Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.](#)
- n) Psychiatric Adjustment Payment. 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

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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.

o) Rural Adjustment Payment. 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)†) 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.

q)†) 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

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in order to qualify for a payment or payment adjustment. In addition, only information that was submitted expressly for the purpose of qualifying for the payment or payment adjustment under review shall be considered by the Department. Information that has been submitted to the Department for other purposes will not be considered during the review process.

(Source: Amendment at 27 Ill. Reg. 4386, effective February 24, 2003)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF CORRECTION TO NOTICE ONLY

- 1) Heading of the Part: Plumbing Contractor Registration Code
- 2) Code Citation: 77 Ill. Adm. Code 894
- 3) The Notice of Adopted Rules(s) being corrected appeared at 27 Ill. Reg. 3063, dated February 21, 2003.
- 4) The Information being corrected is as follows:
Corrections are necessary to items 11, 13, and 15 of the Notice of Adopted Rules.

The following differences between the proposed and final rule are being added to Item 11.

In Section 894.20(a)(7) a new subsection (D) is added, stating that plumbing contractor letters of credit shall expire on April 30 of each year.

In Section 894.80(a), the annual fee for plumbing contractor registration was changed from \$300 to \$100.

Section 894.40(d), concerning public liability coverages as described on the Certificate of Insurance, was proposed as Section 894.30(f), but was moved to Section 894.40(d) at second notice.

The response to item 13 is should be changed from “yes” to “no”. The rulemaking will not replace an emergency rule currently in effect, because the emergency rule expired on August 17, 2002.

Item 15 incorrectly states that the rules include a fee of \$300 annually for contractor registration. The fee for annual plumbing contractor registration was reduced to \$100. The correct fee amount is stated in the rules, only the Notice of Adopted Rules was incorrect.

JOINT COMMITTEE ON ADMINISTRATIVE RULES

MARCH AGENDA

SCHEDULED MEETING:

STRATTON OFFICE BUILDING
ROOM C-1
SPRINGFIELD, ILLINOIS
9:00 A.M.
MARCH 11, 2003

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

PROPOSED RULEMAKINGS

Agriculture

1. Illinois Pesticide Act (8 Ill. Adm. Code 250)
 - First Notice Published: 27 Ill. Reg. 1 – 1/3/03
 - Expiration of Second Notice: 4/6/03

Attorney General

2. Tobacco Product Manufacturers' Escrow Enforcement Act (14 Ill. Adm. Code 250)
 - First Notice Published: 26 Ill. Reg. 17869 – 12/20/02
 - Expiration of Second Notice: 4/6/03

JOINT COMMITTEE ON ADMINISTRATIVE RULES

MARCH AGENDA

3. Motor Vehicle Advertising (14 Ill. Adm. Code 475)
 - First Notice Published: 26 Ill. Reg. 16880 – 11/22/02
 - Expiration of Second Notice: 4/3/03

Central Management Services

4. Pay Plan (80 Ill. Adm. Code 310)
 - First Notice Published: 26 Ill. Reg. 16351 – 11/8/02
 - Expiration of Second Notice: 3/21/03

Children and Family Services

5. Reports of Child Abuse and Neglect (89 Ill. Adm. Code 300)
 - First Notice Published: 26 Ill. Reg. 16353 – 11/8/02
 - Expiration of Second Notice: 3/12/03

Commerce Commission

6. Provision of Advanced Telecommunications Services (83 Ill. Adm. Code 733)
 - First Notice Published: 26 Ill. Reg. 16682 – 11/15/02
 - Expiration of Second Notice: 3/29/03

7. Interconnection (83 Ill. Adm. Code 790)
 - First Notice Published: 26 Ill. Reg. 5486 – 4/19/02
 - Expiration of Second Notice: 3/26/03

8. Interconnection (Repeal) (83 Ill. Adm. Code 790)
 - First Notice Published: 26 Ill. Reg. 5514 – 4/19/02
 - Expiration of Second Notice: 3/26/03

Corrections

9. Discipline and Grievances (20 Ill. Adm. Code 504)
 - First Notice Published: 26 Ill. Reg. 18065 – 12/27/02
 - Expiration of Second Notice: 4/4/03

Deaf and Hard of Hearing Commission

10. Rulemaking, Public Information and Organization (2 Ill. Adm. Code 3300)

JOINT COMMITTEE ON ADMINISTRATIVE RULES

MARCH AGENDA

-First Notice Published: 26 Ill. Reg. 16390 – 11/8/02

-Expiration of Second Notice: 3/13/03

Education

11. Certification (23 Ill. Adm. Code 25)
 - First Notice Published: 26 Ill. Reg. 15368 – 11/1/02
 - Expiration of Second Notice: 3/12/03
12. Standards for Administrative Certification (23 Ill. Adm. Code 29)
 - First Notice Published: 26 Ill. Reg. 14360 – 10/4/02
 - Expiration of Second Notice: 3/12/03

Human Services

13. Temporary Assistance for Needy Families (89 Ill. Adm. Code 112)
 - First Notice Published: 26 Ill. Reg. 17573 – 12/13/02
 - Expiration of Second Notice: 3/27/03
14. Aid to the Aged, Blind or Disabled (89 Ill. Adm. Code 113)
 - First Notice Published: 26 Ill. Reg. 17585 – 12/13/02
 - Expiration of Second Notice: 3/27/03
15. General Assistance (89 Ill. Adm. Code 114)
 - First Notice Published: 26 Ill. Reg. 17595 – 12/13/02
 - Expiration of Second Notice: 3/27/03
16. Food Stamps (89 Ill. Adm. Code 121)
 - First Notice Published: 26 Ill. Reg. 17605 – 12/13/02
 - Expiration of Second Notice Period: 3/27/03
17. Administration of Social Service Programs (89 Ill. Adm. Code 130)
 - First Notice Published: 26 Ill. Reg. 14463 – 10/4/02
 - Expiration of Second Notice: 4/3/03

Labor Relations Board

18. General Procedures (80 Ill. Adm. Code 1200)
 - First Notice Published: 26 Ill. Reg. 9065 – 6/28/02
 - Expiration of Second Notice: 4/9/03

JOINT COMMITTEE ON ADMINISTRATIVE RULES

MARCH AGENDA

19. Representation Proceedings (80 Ill. Adm. Code 1210)
 - First Notice Published: 26 Ill. Reg. 9088 – 6/28/02
 - Expiration of Second Notice: 4/9/03
20. Unfair Labor Practice Proceedings (80 Ill. Adm. Code 1220)
 - First Notice Published: 26 Ill. Reg. 9122 – 6/28/02
 - Expiration of Second Notice: 4/9/03
21. Impasse Resolution (80 Ill. Adm. Code 1230)
 - First Notice Published: 26 Ill. Reg. 9138 – 6/28/02
 - Expiration of Second Notice: 4/9/03

Nuclear Safety

22. Licensing of Radioactive Material (32 Ill. Adm. Code 330)
 - First Notice Published: 26 Ill. Reg. 17623 – 12/13/02
 - Expiration of Second Notice: 3/19/03
23. Standards for Protection Against Radiation (32 Ill. Adm. Code 340)
 - First Notice Published: 26 Ill. Reg. 17032 – 12/2/02
 - Expiration of Second Notice: 3/21/03

Professional Regulation

24. Nursing and Advanced Practice Nursing Act – Advanced Practice Nurse (68 Ill. Adm. Code 1305)
 - First Notice Published: 26 Ill. Reg. 16812 – 11/15/02
 - Expiration of Second Notice: 3/15/03
25. Professional Boxing and Wrestling Act (68 Ill. Adm. Code 1370)
 - First Notice Published: 26 Ill. Reg. 17639 – 12/13/02
 - Expiration of Second Notice: 3/20/03
26. Professional Counselor and Clinical Professional Counselor Licensing Act (68 Ill. Adm. Code 1375)
 - First Notice Published: 26 Ill. Reg. 18195 – 12/27/02
 - Expiration of Second Notice: 4/3/03

Public Aid

JOINT COMMITTEE ON ADMINISTRATIVE RULES

MARCH AGENDA

27. Practice in Administrative Hearings (89 Ill. Adm. Code 104)
-First Notice Published: 26 Ill. Reg. 15261 – 10/25/02
-Expiration of Second Notice: 3/12/03

Secretary of State

28. Procedures and Standards (92 Ill. Adm. Code 1001)
-First Notice Published: 26 Ill. Reg. 18209 – 12/27/02
-Expiration of Second Notice: 3/27/03

State Board of Elections

29. The Campaign Financing Act (26 Ill. Adm. Code 100)
-First Notice Published: 26 Ill. Reg. 12521 – 8/16/02
-Expiration of Second Notice: 3/25/03

30. Practice and Procedure (26 Ill. Adm. Code 125)
-First Notice Published: 26 Ill. Reg. 12527 – 8/16/02
-Expiration of Second Notice: 3/25/03

State Fire Marshal

31. Storage, Transportation, Sale and Use of Petroleum and Other Regulated Substances (41 Ill. Adm. Code 170)
-First Notice Published: 26 Ill. Reg. 15422 – 11/1/02
-Expiration of Second Notice: 3/12/03

32. Storage, Transportation, Sale and Use of Gasoline and Volatile Oils (41 Ill. Adm. Code 180)
-First Notice Published: 26 Ill. Reg. 14406 – 10/4/02
-Expiration of Second Notice: 3/12/03

State Police

33. Firearm Transfer Inquiry Program (20 Ill. Adm. Code 1235)
-First Notice Published: 26 Ill. Reg. 17342 – 12/6/02
-Expiration of Second Notice: 3/12/03

State Toll Highway Authority

JOINT COMMITTEE ON ADMINISTRATIVE RULES

MARCH AGENDA

34. State Toll Highway Rules (92 Ill. Adm. Code 2520)
-First Notice Published: 26 Ill. Reg. 15539 – 11/1/02
-Expiration of Second Notice: 3/12/03

EMERGENCY AND PEREMPTORY RULEMAKINGS

Professional Regulation

35. Dietetic and Nutrition Services Practice Act (68 Ill. Adm. Code 1245) (Emergency)
-Notice Published: 27 Ill. Reg. 3121 – 2/21/03
36. Environmental Health Practitioner Licensing Act (68 Ill. Adm. Code 1247) (Emergency)
-Notice Published: 27 Ill. Reg. 3143 – 2/21/03

Public Health

37. Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300) (Emergency)
-Notice Published: 27 Ill. Reg. 2181 – 2/7/03
38. Sheltered Care Facilities Code (77 Ill. Adm. Code 330) (Emergency)
-Notice Published: 27 Ill. Reg. 2202 – 2/7/03
39. Illinois Veterans' Homes Code (77 Ill. Adm. Code 340) (Emergency)
-Notice Published: 27 Ill. Reg. 2222 – 2/7/03
40. Intermediate Care for the Developmentally Disabled Facilities Code (77 Ill. Adm. Code 350) (Emergency)
-Notice Published: 27 Ill. Reg. 2238 – 2/7/03
41. Long-Term Care for Under Age 22 Facilities Code (77 Ill. Adm. Code 390) (Emergency)
-Notice Published: 27 Ill. Reg. 2258 – 2/7/03
42. Visa Waiver Program for International Medical Graduates (77 Ill. Adm. Code 591) (Emergency)
-Notice Published: 27 Ill. Reg. 2277 – 2/7/03

EXEMPT RULEMAKINGS

JOINT COMMITTEE ON ADMINISTRATIVE RULES

MARCH AGENDA

Pollution Control Board

43. RCRA Permit Program (35 Ill. Adm. Code 703)
 - Proposed Date: 26 Ill. Reg 15541 - 11/1/02
 - Adopted Date: 2/28/03
44. Procedures for Permit Issuance (35 Ill. Adm. Code 705)
 - Proposed Date: 26 Ill. Reg. 15677 - 11/1/02
 - Adopted Date: 2/28/03
45. Hazardous Waste Management System: General (35 Ill. Adm. Code 720)
 - Proposed Date: 26 Ill. Reg. 15721 - 11/1/02
 - Adopted Date: 2/28/03
46. Standards for Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities (35 Ill. Adm. Code 724)
 - Proposed Date: 26 Ill. Reg 15737 - 11/1/02
 - Adopted Date: 2/28/03
47. Interim Status Standards for Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities (35 Ill. Adm. Code 725)
 - Proposed Date: 26 Ill. Reg. 16112 - 11/1/02
 - Adopted Date: 2/28/03
48. Standards for the Management of Specific Hazardous Waste and Specific Types of Hazardous Waste Management Facilities (35 Ill. Adm. Code 726)
 - Proposed Date: 26 Ill. Reg. 16125 - 11/1/02
 - Adopted Date: 2/28/03

AGENCY RESPONSES

Public Health

49. Plumbing Contractor Registration Code (77 Ill. Adm. Code 894; 26 Ill Reg 5070)

Secretary of State

50. Uniform Partnership Act (14 Ill. Adm. Code 165; 26 Ill. Reg. 12598)

JOINT COMMITTEE ON ADMINISTRATIVE RULES

MARCH AGENDA

51. Revised Uniform Limited Partnership Act (14 Ill. Adm. Code 170; 26 Ill. Reg. 12601)
52. Limited Liability Company Act (14 Ill. Adm. Code 178; 26 Ill. Reg. 12605)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of February 18, 2003 through February 24, 2003 and have been scheduled for review by the Committee at its March 11, 2003 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.

Second Notice Expires	Agency and Rule	Start Of First Notice	JCAR Meeting
4/3/03	<u>Department of Human Services</u> , Administration of Social Service Programs (89 Ill. Adm. Code 130)	10/4/02 26 Ill. Reg. 14463	3/11/03
4/3/03	<u>Office of the Attorney General</u> , Motor Vehicle Advertising (14 Ill. Adm. Code 475)	11/22/02 26 Ill. Reg. 16880	3/11/03
4/4/03	<u>Department of Corrections</u> , Discipline and Grievances (20 Ill. Adm. Code 504)	12/27/02 26 Ill. Reg. 18065	3/11/03
4/6/03	<u>Office of the Attorney General</u> , Tobacco Product Manufacturers' Escrow Enforcement Act (14 Ill. Adm. Code 250)	12/20/02 26 Ill. Reg. 17869	3/11/03
4/6/03	<u>Department of Agriculture</u> , Illinois Pesticide Act (8 Ill. Adm. Code 250)	1/3/03 27 Ill. Reg. 1	3/11/03

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

4/9/03	<u>Illinois Labor Relations Board</u> , General Procedures (80 Ill. Adm. Code 1200)	6/28/02 26 Ill. Reg. 9065	3/11/03
4/9/03	<u>Illinois Labor Relations Board</u> , Representation Proceedings (80 Ill. Adm. Code 1210)	6/28/02 26 Ill. Reg. 9088	3/11/03
4/9/03	<u>Illinois Labor Relations Board</u> , Unfair Labor Practice Proceedings (80 Ill. Adm. Code 1220)	6/28/02 26 Ill. Reg. 9122	3/11/03
4/9/03	<u>Illinois Labor Relations Board</u> , Impasse Resolution (80 Ill. Adm. Code 1230)	6/28/02 26 Ill. Reg. 9138	3/11/03

EASTERN ILLINOIS UNIVERSITY

NOTICE OF PUBLICATION ERROR

- 1) Heading of the Part: Organization and Public Information
- 2) Code Citation: 2 Ill. Adm. Code 6000
- 3) Register citation of adopted rulemaking and other pertinent action:

26 Ill. Reg.18235 Effective December 27, 2002
27 Ill. Reg. 1504 Effective January 31, 2003
- 4) Explanation: It has been brought to our attention that rule 2 Ill. Adm. Code 6000 was inadvertently published twice with two separate effective dates. The Rules that should be retained and codified were published in Volume 26, Issue 52, of the Illinois Register dated 12/27/2002. The Rules that should be voided were published in Volume 27, Issue 5, dated 01/31/2003.

ILLINOIS STATE BOARD OF ELECTIONS

NOTICE OF PUBLICATION ERROR

- 1) Heading of the Part: Registration of Voters
- 2) Code Citation: 26 Ill. Adm. Code 216
- 3) Register citation of proposed or adopted rulemaking and other pertinent action: January 10, 2003. 27 Ill. Reg. 444
- 4) Explanation: The “Notice of Withdrawal of Proposed Amendments” was published as a Pollution Control Board Action when in fact it is a State Board of Elections Rule.

SECRETARY OF STATE

NOTICE OF WITHDRAWAL TO MEET THE RECOMMENDATION OF THE
JOINT COMMITTEE ON ADMINISTRATIVE RULES

- 1) Heading of the Part: Uniform Partnership Act
- 2) Code Citation: 14 Ill. Adm. Code 165
- 3)

<u>Section Numbers</u>	<u>Action</u>
165.50	Withdrawal
- 4) Date notice of Proposed Amendments Published in the Illinois Register: August 16, 2002, 26 Ill Reg. 12598
- 5) Date JCAR Statement of Objection Published in the Register: December 6, 2002, 26 Ill. Reg.17437
- 6) Summary of Action Taken by the Agency: The Business Services Department of the Secretary of State will accept the Recommendation of the Joint Committee and withdraw the above-captioned rulemaking, seek statutory authorization to retain a portion of funds submitted to it that exceed the amount owed to the Department, and then pursue rulemaking listing standards as to how it will issue refunds, if necessary.

SECRETARY OF STATE

NOTICE OF WITHDRAWAL TO MEET THE RECOMMENDATION OF THE
JOINT COMMITTEE ON ADMINISTRATIVE RULES

- 1) Heading of the Part: Revised Uniform Limited Partnership Act
- 2) Code Citation: 14 Ill. Adm. Code 170
- 3)

<u>Section Numbers</u>	<u>Action</u>
170.30	Withdrawal
- 4) Date notice of Proposed Amendments Published in the Illinois Register: August 16, 2002, 26 Ill Reg. 12601
- 5) Date JCAR Statement of Objection Published in the Register: December 6, 2002, 26 Ill. Reg.17438
- 6) Summary of Action Taken by the Agency: The Business Services Department of the Secretary of State will accept the Recommendation of the Joint Committee and withdraw the above-captioned rulemaking, seek statutory authorization to retain a portion of funds submitted to it that exceed the amount owed to the Department, and then pursue rulemaking listing standards as to how it will issue refunds, if necessary.

SECRETARY OF STATE

NOTICE OF WITHDRAWAL TO MEET THE RECOMMENDATION OF THE
JOINT COMMITTEE ON ADMINISTRATIVE RULES

- 1) Heading of the Part: Limited Liability Company Act
- 2) Code Citation: 14 Ill. Adm. Code 178
- 3)

<u>Section Numbers</u>	<u>Action</u>
178.60	Withdrawal
- 4) Date notice of Proposed Amendments Published in the Illinois Register: August 16, 2002, 26 Ill Reg. 12605
- 5) Date JCAR Statement of Objection Published in the Register: December 6, 2002, 26 Ill. Reg.17439
- 6) Summary of Action Taken by the Agency: The Business Services Department of the Secretary of State will accept the Recommendation of the Joint Committee and withdraw the above-captioned rulemaking, seek statutory authorization to retain a portion of funds submitted to it that exceed the amount owed to the Department, and then pursue rulemaking listing standards as to how it will issue refunds, if necessary.

ILLINOIS ADMINISTRATIVE CODE

Issue Index

Rules acted upon in Volume 27, Issue 10 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.

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