**Section 101.100 Community mental health and developmental disabilities service provider participation fee trust fund**

a) Definitions

For the purposes of this Section, the following terms are defined:

"Actual payments." The absolute amount of Medicaid payments received by a provider from the Department, per written agreement, for the delivery of Medicaid-reimbursable services during the fee year.

"Applicable provider" or "provider." A community agency from which the Department purchases services through payments that are matched by federal funds under Medicaid and that the Department has determined to be subject to the provider participation fee.

"Days." Calendar days, unless otherwise specified.

"Department." The Department of Human Services.

"Fee." A fee that each applicable provider shall submit to the community mental health and developmental disabilities services provider participation fee trust fund.

"Fee year." The fiscal year beginning July 1 and ending June 30 for which the fee amount applies.

"Fund." The community mental health and developmental disabilities services provider participation fee trust fund comprising the fees submitted by applicable providers, the interest accrued on the fees, and the related federal Medicaid matching funds.

"Medicaid." Medical assistance issued by the Illinois Department of Public Aid, under the provisions of Title XIX of the Social Security Act (42 USCA 1396 (1998)), for eligible recipients, including Aid to the Aged, Blind and Disabled (AABD), Temporary Assistance to Needy Families (TANF), Medical Assistance No Grant (MANG), and Refugee Repatriate Program (RRP) recipients as well as Title XIX eligible Department of Children and Family Services (DCFS) wards.

"Medicaid payments." Payments made by the Department for services covered under Medicaid for which the State receives federal matching funds.

"Medicaid reimbursed services." A service provided by a provider under an agreement with the Department for which the State receives reimbursement from the Medicaid program and which is subject to the fee process.

"Projected payments." The estimated amount of Medicaid payments to be received by a provider from the Department, per written agreement, for the delivery of Medicaid-reimbursable services during the fee year.

b) Fees

1) Calculation of projected fees

Each year the Department shall calculate a fee which shall be paid by applicable providers. The fee amounts due to the fund by applicable providers shall be based on the projected amount of Medicaid payments to be made by the Department to the provider for the year taking into consideration:

A) The unit rates for services;

B) The units of service billed by the assessed provider for the year prior to the fee year; and

C) Any other factors which will influence a change in the number of units of service to be billed during the fee year.

2) Differential fee collection schedule

A) The Department shall establish a differential fee collection schedule for any provider whose projected Medicaid payments during the current fee year exceeds the actual Medicaid payments for the year prior to the fee year by more than 20 percent.

B) The Department shall establish a differential fee collection schedule for such providers which reflects the increasing payments for the current fee year.

C) The differential fee collection schedules for these providers will require lesser fee submittals during the first quarter with gradually increasing fee submittals according to the providers' projected growth in Medicaid receipts.

3) Adjustment of inaccurate projections

A) If the Department determines that any fee amount assessed a provider was incorrect, the Department will correct the fee error.

i) The Department will issue a revised fee amount for the quarter.

ii) The Department will adjust the fee amounts due for subsequent quarters of the fee year.

B) The Department shall monitor quarterly the ratio of actual to projected total gross payments for those assessed providers whose estimated increase in gross total payment for the fee year is expected to exceed 20 percent.

i) When the accumulated actual fees due to the fund by the assessed provider differ by more than 10 percent from the accumulated projected fees, the Department shall issue a revised fee amount for the immediate calendar quarter and a revised collection schedule for the remainder of the fee year. When this occurs, the provider shall submit the revised fee amount within 30 days after the date of postmark on the Department's written notification of the change.

ii) When the accumulated actual fees due to the fund by an assessed provider are less than the accumulated projected fee amounts, the Department shall return to the provider the appropriate share of overpaid fees.

4) Calculation of provider participation fees

The Department shall multiply the projected Medicaid payments for services which it has determined to be subject to the provider participation fee for the fee year of individual providers by any amount not greater than 15 percent to determine the fee amount owed to the fund.

5) Notification of fee due date

The Department shall notify each assessed provider, in writing, of the amount of the fee 30 days prior to the required fee due date. The Department may modify the notification timeframes and extend the required fee due date for good cause shown.

6) Provider submission of fees

A) Each provider shall submit the specified fee in equal quarterly amounts on or before the first business day of each calendar quarter.

B) Due dates for provider submission of quarterly fee payments shall be January 2, April 1, July 1, and October 1, or, if these dates are on weekends or holidays, the first business day immediately following.

7) Delayed fee collection schedules

A) The Secretary of the Department is authorized to establish delayed fee collection schedules for providers that are unable to make timely payments due to financial difficulties.

B) Delayed fee collection schedules shall be granted only under extraordinary circumstances to qualified providers that meet all of the requirements in subsections (b)(7)(C) and (D).

C) Denial of an application to borrow provider participation fee funds from a financial institution or other lending entity.

D) A signed written agreement with the Department specifying the terms and conditions of the delayed fee collection schedule, which shall contain the following provisions:

i) Specific reason(s) for the establishment of the delayed fee collection schedule;

ii) Specific dates on which submission of the fees will be received by the Department and the amount of the fees which will be received on each specified date described;

iii) The interest that shall be due from the provider as a result of the establishment of the delayed fee collection schedule;

iv) A certification stating that, should the provider entity be sold, the new owners shall be made aware of the liability and shall assume responsibility for repaying the debt to the Department in accordance with the original agreement;

v) A certification stating that all information forwarded to the Department in support of the establishment of the delayed fee collection schedule request is true and accurate to the best of the signatory's knowledge; and

vi) Such other terms and conditions that may be required by the Department.

E) In order to receive consideration for delayed fee collection schedules, providers shall forward their requests in writing (telefax requests are acceptable) to the Department. Requests must be received within five working days after the date of the Department's notification of the provider participation fee due for the subject quarter. All telefax requests must be followed-up with original written requests. All requests shall include:

i) An explanation of the circumstances creating the need for the delayed fee collection schedule;

ii) Supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the provider's clients;

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

F) The Department shall notify the provider, in writing, of its decision with regard to the request for the establishment of a delayed fee collection schedule. An agreement shall be issued to the provider for all approved requests. The agreement shall be signed by the provider's administrator, owner, chief executive officer, or other authorized representative and must be received by the Department before the first scheduled fee submittal date listed in the delayed fee collection schedule.

i) The Department shall waive the penalties for delinquent and/or deficient fee submittal upon the approval of the provider's request for establishment of a delayed fee collection schedule. When a provider's request for establishment of a delayed fee collection schedule is approved and the Department receives the signed agreement in accordance with this subsection, such penalties shall be permanently waived for the subject quarter unless the provider reneges on the conditions of the agreement. When the provider reneges on the conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

ii) The delayed fee collection schedule shall include interest at a rate not to exceed the State's borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (b)(7)(E).

iii) When a provider has requested and received Department approval for a delayed fee collection schedule, the provider shall not receive approval for subsequent delayed fee collection schedules until such time as the terms and conditions of any current delayed fee collection agreement has been satisfied. The waiver of penalties described in subsection (b)(7)(F)(i) shall not apply to a provider that has not satisfied the terms and conditions of any current delayed fee collection agreement.

8) Penalty for delinquent or deficient fees

Any provider that fails to submit the fee when due, or submits less than the full amount due, shall be assessed a penalty of 10 percent of the delinquency or deficiency for each month, or fraction thereof, computed on the full amount of the delinquency or deficiency, which includes any penalty accrued and not paid, from the time the fee was due.

9) Notification to comptroller

A) The Secretary may take action to notify the Office of the Comptroller to collect any amount of monies owed by the provider to the fund.

B) The Secretary may take action against providers failing to submit any delinquent or deficient fee or penalty including:

i) Suspension of payments;

ii) Cancellation of the provider contract or agreement; and

iii) Refusal to issue, extend, or reinstate the provider contract or agreement.

c) Local government funds certification

Providers may use local government funds as a source to meet their obligated, quarterly assessed fee amount in part or in whole.

1) If local government funds are used, the provider shall certify the planned spending of these local funds for the specified services in lieu of actual cash payment to the fund by providing a statement from each local government funder stating the intent of that funder to contribute the applicable portion of the fee amount, signed by the chairperson of the local government funder taxing authority.

2) If the certification process is used, the provider shall submit to the Department, by October 31 of the year following the fee year, an annual audit statement from a certified public accounting firm which demonstrates that the local government funds were spent for the intended service and in the amounts required according to the fee amount.

3) Expenditure of funds on Medicaid Services

A) If the local government funds were not spent for the Medicaid service as required:

i) The provider shall submit to the State by October 31 of the year following the fee year the amount of the fee which was not spent;

ii) A fine equal to 25 percent of the amount of the fee not properly covered by the local government funds certification process.

B) This payment shall be submitted to the State Treasury by October 31 of the year following the fee year.

d) Deposit of revenue

Deposits to the fund shall consist of:

1) Federal revenues received under Title XIX of the Social Security Act as a result of the increased rates paid by the Department to providers of Medicaid-reimbursable services;

2) The fees paid by providers of Medicaid-reimbursable services under agreement with the Department which are eligible for reimbursement from Medicaid and which are subject to the fee process;

3) The interest earned on the deposits to the fund; and

4) The revenues generated from fines and penalties levied by the Department on providers in accordance with subsection (c)(3).

e) Protection from reduction

1) The moneys in the fund shall be exempt from any State budget reduction Acts.

2) The funds shall not be used to replace any funds otherwise appropriated to the Medicaid program by the Illinois General Assembly.

f) Administration of contingency reserves

1) Moneys paid from the fund shall be used first to:

A) Pay for the administrative expenses incurred by the Department in performing the duties authorized by Section 18.1 of the Mental Health and Developmental Disabilities Administrative Act [20 ILCS 1705/18.1];

B) Pay any amounts reimbursable to the federal government, which are required to be paid by State warrant.

2) Disbursements from the fund shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Department.

3) The Department shall establish a contingency reserve not to exceed three percent in any fee year of the total amount of the revenues described in subsection (d).

g) Fund expenditures

The Department shall spend 100 percent of the moneys in the fund during the fee year from which the monies were collected to reimburse providers for the delivery of Medicaid services less:

1) The administrative expenses incurred in performing the duties authorized by Section 18.1 of the Mental Health and Developmental Disabilities Administrative Act; and

2) A maximum of three percent of the total deposits made to the fund in any fee year for the contingency reserve.

h) Provider assurance

1) In the aggregate, providers under contract with the Department to provide Medicaid reimbursable services that are subject to the fee payment process are entitled to a return of 100 percent of the fee amount paid during any fee year:

A) Plus the federal funding portion;

B) Less the administration expenses incurred by the Department in performing the activities authorized; and

C) Less the allowed three percent contingency reserve.

2) No provider shall receive back less than the amount required as a fee for any given fee year.

i) Department records

The Department shall maintain records showing the amount of money paid by each provider into the fund and the amount of money that has been paid from the fund to each provider for each fee year.

j) Annual audit

1) The Department shall conduct an annual audit of the fund to determine that:

A) Receipts were appropriate and accurate;

B) Disbursements were appropriate and accurate;

C) Delayed fee collection schedules were justified and approved;

D) Interest and penalties were properly calculated and imposed;

E) Local government funds were properly certified;

F) Contingency reserves were accurately calculated;

G) Records were appropriate, complete and correct.

2) Any errors or deficiencies identified as a result of such audit shall be corrected on a timely basis.

k) Fee correction and recovery

If the Department's annual audit identifies erroneous fee or reimbursable payment amounts, then it shall:

1) Correct the fee payment amount and any related fine and notify the provider;

2) Correct the reimbursable payment amount to the provider; or

3) Take the action necessary to recover the required fee or reimbursed payment amount from the provider.

l) Applicability of provider participation fees

1) The Department shall determine which services and which providers will be subject to the provider participation fees.

2) The Department may choose to terminate or revise its policies concerning the computation and/or collection of provider participation fees if laws or regulations are implemented affecting state financing of Medicaid services with mandatory provider participation fees.

3) If the Department terminates the collection of provider participation fees and a positive balance remains in the fund, the Department shall expend the balance as follows:

A) Refund to each provider any portion of the annual fees the provider had submitted, but for which the provider had not yet been reimbursed.

B) Expend whatever is required for any outstanding costs related to the administration of the provider participation fee initiative or to its termination.

C) Distribute any remaining balance among contributing providers proportionally to each provider's contributions to the fund during the 12-month period prior to termination.

m) Appeals procedure

1) Appealable decisions – A provider may request a hearing on the following issues:

A) The initial assessment or change in the amount of the required payment;

B) An audit finding that a provider is required to reimburse the Department for a fee or payment.

2) Notice of appeal rights – The Department shall inform the provider of the right to appeal and the appeal procedure whenever the provider is notified of the initial assessment or change in the amount of the required payment, or of an audit finding that a provider is required to reimburse the Department for a fee or payment.

3) Request for hearing – A provider may appeal the Department's decision by requesting a hearing in writing within 10 days after receipt of the decision. The request shall be sent to:

Bureau of Administrative Hearings

Department of Human Services

100 South Grand Avenue East

Springfield IL 62762

4) Stay of proceedings – The request for an appeal shall stay any proceedings or decision taken concerning the provider until the resolution of the appeal.

5) Upon request of the provider at any time prior to the scheduled hearing, the provider may request an informal conference with the Division of Disability and Behavorial Health Services to determine the facts and issues and to resolve any conflicts as amicably as possible.

6) Hearing officer – The hearing shall be conducted by a hearing officer appointed by the Secretary.

7) Scheduling and notice of hearings – Within 60 days after the receipt after the appeal, the hearing officer shall schedule a hearing, to be held in the Department's central offices or a place agreed to by the hearing officer, the Department staff involved and the provider. The hearing officer shall send written notice of the hearing to the provider via certified mail. The notice shall contain:

A) A statement of the nature of the hearing;

B) A statement of the time and place of the hearing;

C) A statement of the right to be represented by an attorney at the provider's expense.

8) Continuances – The hearing officer may, upon good cause shown, grant a continuance requested by the provider.

9) Conduct of hearings

A) The hearing officer shall regulate the course of the hearings; hold informal conferences for the purpose of resolving the case; dispose of procedural issues; continue the hearing from time to time when necessary; examine witnesses and rule upon the relevancy of evidence.

B) At the hearing, the provider and the Department may present written and oral evidence. The Department shall have the burden of proving by substantial evidence that the decision was made in accordance with the statutes and this Section. Upon conclusion of the Department's presentation, the provider may present written and oral evidence.

C) The common law rules of evidence shall not be enforced in the hearing. The hearing officer shall conduct the hearing in a manner that allows participants to present their evidence fully and freely. Either party may ask questions of each other or any witness, and the hearing officer may ask questions of either party or any witness. Questions impeaching the witness' character or credentials shall be improper.

D) The hearing shall be taped or stenographically recorded. The tape or a copy of the transcript shall be retained by the Department. If the provider appeals the hearing officer's decision, a copy of the record shall be provided to the provider upon request.

10) Standard of review – In all appeals, the hearing officer shall decide whether there was substantial evidence showing that the Department's decision was made in accordance with statute and this Section.

11) Decision – Within 10 working days after the hearing, the hearing officer shall issue a written decision that upholds, modifies or reverses the Department's decision. The decision shall contain the reasons for the hearing officer's action. The hearing officer shall mail copies to the provider and the Department via certified mail. The decision shall be accompanied by a letter that informs the provider of the right to appeal the decision and state the procedure for requesting an appeal.

12) Appeal of the hearing officer's decision

A) The provider may request a review of the hearing officer's decision by the Secretary or his or her designee no more than 20 days after the receipt of the hearing officer's decision.

B) Upon receipt of the request for review, the Secretary or designee shall review the hearing officer's decision and copies of all documents considered at the hearing. Within 20 working days after receipt of the request for review, the Secretary or his or her designee shall issue a decision upholding, modifying or reversing the hearing officer's decision. The Secretary or his and her designee shall uphold the decision if he or she determines that the decision was supported by substantial evidence. Copies of the decision shall be sent to the provider, the Department and the hearing officer.

C) The Secretary's decision shall constitute a final administrative decision in accordance with Section 3-101 of the Administrative Review Law [735 ILCS 5/3-101].

(Source: Amended at 23 Ill. Reg. 11118, effective August 24, 1999)