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

a) C-13 Invoice Voucher Advance Payments

1) The C-13 invoice voucher, when used as an advanced payment, is an exception to the regular reimbursement process. It may be issued only under extraordinary circumstances to qualified providers of medical assistance services. C-13 advance payments will be made only to a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:

A) are enrolled with the Department;

B) have experienced an emergency which necessitates C-13 advance payments. Emergency in this instance is defined as a circumstance under which withholding of the advance payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired; or

ii) cash flow problems encountered by a provider or group of providers which are unrelated to agency technical system problems. These situations include problems which are exclusively those of the providers or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider, adversely impacting on the ability to promptly serve the clients;

C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;

ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;

iii) for hospitals, the hospital must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;

iv) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;

v) for sole source pharmacies in a community which are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;

vi) for government-owned facilities, this subsection (a)(1)(C) may be waived if the cash flow criterion under subsection (a)(1)(B)(ii) is met; and

vii) for providers who have filed for Chapter 11 bankruptcy, this subsection (a)(1)(C) may be waived if the cash flow criterion under subsection (a)(1)(B)(ii) are met;

D) sign an agreement with the Department which specifies the terms of advance payment and subsequent repayment. The agreement will contain the following provisions:

i) specific reasons for advanced payments;

ii) specific amount agreed to be advanced;

iii) specific date to begin recoupment; and

iv) method of recoupment (percentage of payable amount of each Medicaid Management Information System (MMIS) voucher, specific amount per month, a warrant intercept, or a combination of the three recovery methods).

2) Determination of amount of payment to be issued shall be based on anticipated future payments as determined by the Department.

3) Approval Process

A) In order to obtain C-13 advance payments, providers must submit their request in writing (telefacsimile and email requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:

i) an explanation of the circumstances creating the need for the advance payments;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the amount of the advance required.

B) An agreement will be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to release of the warrant.

C) C-13 advance payments shall be authorized for the provider following approval by the Administrator of the Division of Medical Programs or designee. Once all requirements of this subsection (a)(3) are met, the Administrator will authorize payment within seven days.

4) Recoupment

A) Health care entities other than individual practitioners shall be required to sign an agreement stating that, should the entity be sold, the new owners will be made aware of the liability and will assume responsibility for repaying the debt to the Department according to the original agreement.

B) All providers shall sign an agreement specifying the terms of recoupment. An agreed percentage of the total payment to the provider for services rendered shall be deducted from future payments until the debt is repaid. For providers who are properly certified, licensed or otherwise qualified under appropriate State and federal requirements, the recoupment period shall not exceed six months from the month in which payment is authorized. For those providers enrolled but not in good standing (e.g., decertification termination hearing or other adverse action is pending), recoupment will be made from the next available payments owed the provider.

C) In the event that the provider fails to comply with the recoupment terms of the agreement, the remaining balance of any advance payment shall be immediately recouped from claims being processed by the Department. If such claims are insufficient for complete recovery, the remaining balance will become immediately due and payable by check to the Illinois Department of Public Aid. Failure by the provider to remit such check will result in the Department pursuing other collection methods.

5) Prior Agreements

The terms of any agreement signed between the provider and the Department prior to the adoption of this Section or prior to any amendment to this Section will remain in effect, notwithstanding the provisions of this Section.

b) Expedited Claims Payments

1) Expedited claims payments are issued through the regular MMIS payment process and represent an acceleration of the regular payment schedule. They may be issued only under extraordinary circumstances to qualified providers of medical assistance services. Reimbursement through the expedited process will be made only to a hospital qualified and participating under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:

A) are enrolled with the Department;

B) have experienced an emergency which necessitates expedited payments. Emergency in this instance is defined as a circumstance under which withholding of the expedited payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) agency system errors (either automated system or clerical) that have precluded payments, or that have caused erroneous payments such that the provider's ability to provide further services to the clients is severely impaired;

ii) cash flow problems encountered by a provider or group of providers which are unrelated to Department technical system problems. These situations include problems which are exclusively those of the providers (i.e., provider billing system problems) or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider adversely impacting on the ability to serve the clients;

C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;

ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;

iii) for hospitals, the hospitals must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;

iv) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;

v) for sole source pharmacies in a community that are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;

vi) for government-owned facilities, this subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (a)(1)(B)(ii) are met; and

vii) for providers who have filed for Chapter 11 bankruptcy, subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (b)(1)(B)(ii) are met.

2) Reimbursement will be based upon the amount of claims determined payable and be made for a period specified by the Department.

3) Approval Process

A) In order to qualify for expedited payments, providers must submit their request in writing (telefacsimile and email requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:

i) an explanation of the need for the expedited payments; and

ii) supportive documentation to substantiate the emergency nature of the request.

B) Expedited payments shall be authorized for the provider following approval by the Administrator of the Division of Medical Programs or designee.

C) The Department will periodically review the need for any continued expedited payments.

4) Prior Agreements

The terms of any agreement signed between the provider and the Department prior to the adoption of this Section or prior to any amendment to this Section will remain in effect, notwithstanding the provisions of this Section.

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