**Section 140.88 Managed Care Organization Provider Assessment**

a) Definitions

1) "Base Year" means the 12 month period from January 1, 2018 to December 31, 2018

2) "Department" means the Department of Healthcare and Family Services.

3) "Federal employee health benefit" means the program of health benefits plans, as defined in 5 U.S.C. 8901, available to federal employees under 5 U.S.C. 8901 to 8914.

4) "Fund" means the Healthcare Provider Relief Fund.

5) "Managed Care Organization" means an entity operating under a certificate of authority issued pursuant to the Health Maintenance Organization Act [215 ILCS 125] or as a Managed Care Community Network pursuant to Section 5-11 of the Public Aid Code [305 ILCS 5].

6) "Medicaid Managed Care Organization" or "Medicaid MCO" means a Managed Care Organization under contract with the Department to provide services to recipients of benefits in the Medical Assistance Program under Article V of the Public Aid Code, the Children's Health Insurance Program Act [215 ILCS 106], and the Covering ALL KIDS Health Insurance Act [215 ILCS 170]. It does not include contracts the same entity or an affiliated entity maintains for other business.

7) "Medicare" means the federal Medicare program established under Title XVIII of the Social Security Act.

8) "Member months" means the aggregate total number of months all individuals are enrolled for coverage in an MCO during the base year. Member months are determined by the Department for Medicaid MCOs based on enrollment data in its Medicaid Management Information System and by the Department of Insurance for other MCOs based on required filings with the Department of Insurance. Member months do not include months individuals are enrolled in a Limited Health Services Organization, including stand-alone dental or vision plans, a Medicare Advantage Plan, a Medicare Supplement Plan, a Medicaid-Medicare Alignment Initiative Plan pursuant to a Memorandum of Understanding between the Department and the federal Centers for Medicare and Medicaid Services or a Federal Employee Health Benefits Plan.

b) For State Fiscal Years 2020 through 2021, there is imposed upon MCO member months an assessment, calculated on base year data, as follows, for the appropriate tier:

1) Tier 1 − $61.70 per member month;

2) Tier 2 − $1.20 per member month; and

3) Tier 3 − $2.40 per member month.

c) For State Fiscal Year 2022, there is imposed upon MCO member months an assessment, calculated on base year data, as follows, for the appropriate tier:

1) Tier 1 − $69.40 per member month;

2) Tier 2 − $1.20 per member month; and

3) Tier 3 − $2.40 per member month.

d) For State Fiscal Year 2023, there is imposed upon MCO member months an assessment, calculated on base year data, as follows, for the appropriate tier:

1) Tier 1 − $74.40 per member month;

2) Tier 2 − $1.20 per member month; and

3) Tier 3 − $2.40 per member month.

e) For State Fiscal Years 2024 through 2025, there is imposed upon MCO member months an assessment, calculated on base year data, as follows, for the appropriate tier:

1) Tier 1 − $78.90 per member month;

2) Tier 2 − $1.40 per member month; and

3) Tier 3 − $2.40 per member month.

f) The tiers are established as follows:

1) Tier 1 includes the first 4,195,000 member months in a Medicaid MCO for the base year;

2) Tier 2 includes member months over 4,195,000 in a Medicaid MCO during the base year; and

3) Tier 3 includes member months during the base year in an MCO that is not a Medicaid MCO.

g) The assessment payable for State FY 2020 shall be prorated and due and payable in monthly installments, each equaling one-eighth of the assessment for the year, on the first State business day of each month beginning November 1, 2019. The assessment payable for State FY 2021 through 2025 shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the first State business day of each month.

h) The Department shall notify each MCO of its annual assessment and the installment due dates no later than 30 days prior to the first due date of each fiscal year, and the annual assessment and due dates for each subsequent year, at least 30 days prior to the start of each fiscal year.

i) Proceeds from the assessment levied shall be deposited into the Fund, except for those proceeds *upon a county provider as defined in* 305 ILCS 5/15-1 , which *shall be deposited directly into the County Provider Trust Fund* [305 ILCS 5/5H-4].

j) In the event of a merger, acquisition or any similar transaction involving entities subject to the assessment under this Section, the resultant entity shall be responsible for the full amount of the assessment for all entities involved in the transaction, with the member months allotted to tiers as they were prior to the transaction, and no member months shall change tiers as a result of any transaction. An MCO that ceases doing business in the State during any fiscal year shall be liable only for the monthly installments due in months that it operated in the State.

k) An MCO that is liable for the assessment under this Section shall keep accurate and complete records and pertinent documents as may be required by the Department, including but not limited to records of: member months, premium revenue, and plans that provide coverage to individuals who are eligible for Medicare, Medicaid or a federal employee health benefits program. Records required by the Department shall be retained for a period of 4 years after the assessment imposed under this Act to which the records apply is due, or as otherwise provided by law. The Department or the Department of Insurance may audit all records necessary to ensure compliance with this Section and make adjustments to assessment amounts previously calculated based on the results of any such audit.

l) If an MCO fails to make a payment due under this Section in a timely fashion, it shall pay an additional penalty of 5% of the amount of the installment not paid on or before the due date, or any grace period granted, plus 5% of the portion remaining unpaid on the last day of each 30-day period thereafter. The Department is authorized to grant grace periods of up to 30 days upon request of an MCO for good cause due to financial or other difficulties, as determined by the Department. If an MCO fails to make a payment within 60 days after the due date, the Department shall additionally impose a contractual sanction allowed against a Medicaid MCO and may terminate any such contract.

m) For an MCO which is first doing business in the State after 2018, the base year data on which the MCO will be assessed shall be the first year in which the data was available to the Department to calculate the assessment.

(Source: Amended at 47 Ill. Reg. 18024, effective November 21, 2023)