

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER 11-03	2. STATE: ILLINOIS
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: January 1, 2011	

5. TYPE OF PLAN MATERIAL (Check One)
 NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT


COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902 of the Social Security Act	7. FEDERAL BUDGET IMPACT a. FFY 2011 \$ (37.4) million b. FFY 2012 \$ (47.0) million
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A pages 35, ^{AM}122, 123, 124, 127, 129, 130, 131, 131B2, 131D, 131D1, 131F, 138	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): ^{AM} Attachment 4.19-A pages 35, ^{AM}122, 123, 124, 127, 129, 130, 131, 131B2, 131D, 131D1, 131F, 138
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10. SUBJECT OF AMENDMENT:
Hospital inpatient supplemental payments, Hospital outlier payment calculation

11. GOVERNOR'S REVIEW (Check One)
 GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
 OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: 	16. RETURN TO: Department of Healthcare and Family Services Bureau of Program and Reimbursement Analysis Attn: Greg Wilson, Chief 201 South Grand Avenue East Springfield, IL 62763-0001
13. TYPED NAME: Julie Hamos	
14. TITLE: Director of Healthcare and Family Services	
15. DATE SUBMITTED 3/3/11	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUL 09 2013
PLAN APPROVED—ONE COPY ATTACHED	

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME	22. TITLE:

23. REMARKS:
Page 122 eliminated from SPA; Page 128 added to SPA.