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State/Territory Name: IL

State Plan Amendment (SPA) #: 12-016

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CENTERS FOR MEDICARE & MEDICAID SERVICES

June 25, 2014

Julie Hamos, Director
Illinois Department of Healthcare and Family Services
Prescott E Bloom Building
201 South Grand Avenue East
Springfield IL 62763-0002

RE: Illinois State Plan Amendment (SPA) 12-016

Dear Ms. Hamos:

Enclosed for your records are the correct amended plan pages for the amendment submitted under transmittal number (TN) 12-016. This SPA was approved on June 11, 2014. The enclosed amended pages reflect several technical corrections which should have been included with the version sent on June 11, 2014. The CMS-179 form has also been included for your convenience.

If you have any questions, please have a member of your staff contact Michelle Beasley at (312) 353-3746 or by email at michelle.beasley@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 12-016
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: July 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] 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 2012 ($17.9 million)
b. FFY 2013 ($71.2 million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 59, 66, 67, 126, 126A, 127, 131D, 131D1, 137-141 and Page 162 (New), 74A 168

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 59, 66, 67, 126, 126A, 127, 131D, 131D1, 137-141, 74A

10. SUBJECT OF AMENDMENT:
Hospital rate modification and repeal of Excellence in Academic Medicine

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
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Julie Hamos

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED 8-24-12

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Theresa Eagleson
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 11 2014

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: [redacted]

22. TITLE: Deputy Director, Policy + Financial Mgt, CMCS

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: Illinois

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

07/95 4. Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this Section shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level I or a Level II trauma center as required for the adjustment described in Section E. above. In these instances, the adjustments calculated under this Section shall be pro-rated, as applicable, based upon the date that such recognition ceased.

07/95 5. Trauma Center Adjustment Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments required by Section E are as follows:

07/95 a. "Available funds" means funds which have been deposited into the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and which have been appropriated by the Illinois General Assembly.

07/12 b. "Medicaid trauma admission" means those claims billed as admissions, for recipients of medical assistance under Title XIX of the *Social Security Act*, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA 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, 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. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under the age of 18.

a. First Interim Payment

A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

b. Additional Interim Payments

A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under Section D.2.a of this Chapter. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of Section D.2.of this Chapter.

3. Outlier Payments

Except as provided in Section D.2 of this Chapter, payment for outlier cases (described in Chapter V.) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

09/91 E. Reductions to Total Payments

1. Co-payments

07/12 Co-payments will be assessed on inpatient hospital services in accordance with Attachment 4.18-A.

~~a. Co-payments will be assessed on inpatient hospital services in the following amounts:~~

~~i. Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section B.1. of Chapter VIII.) of $325 or more...$3 per day.~~

~~ii. Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section B.1. of Chapter VIII.) of more than $275 but less than $325...$2 per day.~~

~~iii. Inpatient hospital services in hospitals with an alternative cost per diem rate (See Section B.1. of Chapter VIII) of $275 or less... No Co-payment.~~

07/12 ~~b. Co-payments will be assessed under all medical programs administered by the Department except the Children and Family Assistance Program (formerly known as the General Assistance program. Co-payments will not be assessed against individuals under the age of 18, pregnant women (including post-partum women who have given birth within the last six weeks), or group care recipients. Co-payments will be deducted automatically by the Department upon payment for services provided.~~

07/12 ~~c. No provider may deny care or services on account of an individual's inability to pay a co-payment: this requirement, however, shall not extinguish the liability for payment of the co-payment by the individual to whom the care or services were furnished.~~

2. Third- Party Payments

Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

09/91 F. Effect of Change of Ownership on Payments under the DRG Prospective Payment System. When a hospital's ownership changes, the following rules apply:

1. The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.

2. Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

07/97 G. All payments calculated under Sections B and C above, in effect on January 18, 1994, shall remain in effect hereafter.

B) Whose care is primarily paid under Title XIX of the Social Security Act, or if dually eligible under Medicare, after the patient has exhausted their benefits under Medicare.

ii. The LTAC Hospital Supplemental Per Diem rate will not be paid if any of the following conditions are met:

A) The LTAC hospital no longer meets the requirements of subsection A.3.a. of this Chapter, or terminates the agreement required under subsection A.3.a.6. of this Chapter.

B) The patient does not meet the LTAC hospital criteria, as defined in subsection A.3.c.iv. upon admission.

C) The patient's care is primarily paid for by Medicare and the patient has not exhausted their Medicare benefits.

iii. The LTAC Hospital Supplemental Per Diem rate shall be calculated using the LTAC hospital's Inflated Cost Per Diem, as defined in subsection A.3.c.ii. and subtracting the following :

A) The LTAC hospital's Medicaid per diem inpatient rate as calculated in subsection A.2. of this Chapter.

B) The LTAC hospital's disproportionate share (DSH) rate as calculated in subsection C.7. of Chapter VI.

C) The LTAC hospital's Medicaid Percentage Adjustment (MPA) as calculated in subsection C.7. b. of Chapter VI.

D) The LTAC hospital's Medicaid High Volume Adjustment (MHVA) rate as calculated in section F. of Chapter VI.

07/12

iv. The LTAC Supplemental Per Diem rates ~~are~~ effective July 1, 2012 shall be the amount in effect as of October 1, 2010 and adjusted pursuant to Chapter XXXIX. No new hospital may qualify for the program on or after July 1, 2012 ~~for twelve months beginning on October 1 of each year and must be updated every twelve months~~.

v. In the case of an Illinois hospital that begins operations as an LTAC hospital after January 1, 2009, that is designated by Medicare as a long term acute care hospital, and that does not have a filed cost report covering a twelve month period of operation as an LTAC provider, a default Supplemental Per Diem Rate shall be established as follows;

a. For a new LTAC provider that is part of a larger corporately held system of LTAC providers in the state of Illinois, the new providers' supplemental rate shall be the average of all supplemental per diem rates, as calculated in A.3.b.iii, of the other LTAC providers in the system.

b. For a new LTAC provider that is not part of a larger corporately held system of LTAC providers, the new providers' supplemental rate shall be the statewide average of all supplemental per diem rates as calculated in A.3.b.iii.

d. Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive $142.00 per day for hospitals that do not provide obstetrical care and $179.00 per day for hospitals that do provide obstetrical care.

04/05 2. Hospitals qualifying under subsection C.1.a.of this Chapter will also receive the following rates:

a. County owned hospitals as defined in Section C.8 of Chapter II, with more 30,000 Total days will have their rate increased by $455.00 per day.

04/09 b. Hospitals that are not a county owned with more than 30,000 total days will have their rate increased by $354.00 per day for dates of service on or after April 1, 2009.

c. Hospitals with more than 80,000 Total days will have their rate increased by an additional $423.00 per day.

d. Hospitals with more than 4,500 Obstetrical days will have their rate increased by $101.00 per day.

e. Hospitals with more than 5,500 Obstetrical days will have their rate increased by an additional $194.00 per day.

f. Hospitals with an MIUR rate greater than 74 percent will have their rate increased by $147.00 per day.

07/12 g. Hospitals with an average length of stay less than 3.9 days will have their rate increased by $385.00 per day through December 31, 2014 ~~June 30, 2012~~. For dates of service on or after January 1, 2015 ~~July 1, 2012~~, the rate is $131.00.

04/09 h. Hospitals with a MUIR 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 $360.00 per day for dates of service on or after April 1, 2009.

04/09 i. Hospitals receiving payments under subsection (D)(1)(b) that have an average length of stay less than 4 days will have their rate increased by $650.00 per day for dates of service on or after April 1, 2009.

07/06 j. Hospitals receiving payments under subsection (D)(1) that have a MIUR greater than 60 percent will have their rate increased by $320.50 per day.

04/09 k. Hospitals receiving payments under subsection (D)(1)(d) that have a Medicaid inpatient utilization rate greater than 70 percent and have more than 20,000 days will have their rate increased by $185.00 per day for dates of service on or after April 1, 2009.

07/06

l. Hospitals with a Combined MIUR greater than 75 percent, that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate increased by $148.00 per day.

3. Hospitals qualifying under subsection C.1.b. of this Chapter will receive the following rates:

   a. Qualifying hospitals will receive a rate of $421.00 per day.

07/12

   b. Qualifying hospitals with the more than 1,500 Obstetrical days will have their rate increased by $824.00 per day through December 31, 2014 ~~June 30, 2012~~. For dates of service on or after January 1, 2015 ~~July 1, 2012~~, the rate is $369.00.

07/02

4. Hospitals qualifying under subsection C.1.c. of this Chapter will receive the following rates:

   a. Hospitals will receive a rate of $28.00 per day.

   b. Hospitals located in Illinois and outside of HSA 6 that have a Medicaid inpatient utilization rate greater than 60 percent, will have their rate increased by $55.00 per day.

07/12 c. Hospitals located in Illinois and inside HSA 6 that have a Medicaid inpatient utilization rate greater than 80 percent, will have their rate increased by $573.00 per day. For dates of service on or after January 1, 2011 through December 31, 2014~~June 30, 2012~~, this rate shall be increased by an additional $47.00 to $620.00 per day.

07/12 d. Hospitals that are not located in Illinois that have a Medicaid inpatient utilization rate greater than 45 percent will have their rate increased by:

i. $32.00 per day for hospitals that have less than 4,000 total days; or

ii. $363.00 per day for dates of service through December 31, 2014~~June 30, 2012~~, for hospitals that have greater than 4,000 total days but less than 8,000 total days; for dates of service on or after January 1, 2015~~July 1, 2012~~, the increase is $246.00 per day; or

iii. $295.00 per day for dates of service through December 31, 2014~~June 30, 2012~~, for hospitals that have greater than 8,000 total days; for dates of service on or after January 1, 2015~~July 1, 2012~~, the increase is $178.00 per day.

01/06 e. Hospitals with more than 3,200 Total admissions will have their rate increased by $328.00 per day.

5. Hospitals qualifying under subsection C.1.d. of this Section will receive the following rates:

07/02 a. Hospitals will receive a rate of $41.00 per day.

b. Hospitals with a MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $14.00 per day.

04/09 c. Hospitals with a MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $191.00 per day for dates of service on or after April 1, 2009.

07/12 d. Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rates increased by an additional $41.00 per day. For dates of service on or after January 1, 2011 through December 31, 2014~~June 30, 2012~~, this rate shall be further increased by $54.00 per day to $95.00 per day.

07/05 6. Hospitals qualifying under subsection C1.e above will receive $188.00 per day.

7. Hospitals qualifying under subsection C.1.f. of this Section will receive a rate of $55.00 per day.

12/08 8. Hospitals that qualify under subsection(c)(1)(G) of this Section will receive the following rates:

a. Hospitals with an MIUR equal to or less than 19.75 percent will receive a rate of $11.00 per day.

b. Hospitals with an MIUR greater than 19.75 but equal to or less than 20.00 percent will receive a rate of $69.00 per day.

10/03 9. Hospitals qualifying under subsection (c)(1)(H) of this Section will receive a rate of $268.00 per day.

02/08

xi. A qualifying hospital that provided greater than 35,000 days in the safety net hospital base year—$43.25.

xii. A qualifying hospital with two or more graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory", with an average length of stay less than 4 days—$48.00.

07/08

b. For a hospital qualifying under Section (1)(b) of these rules, the rate shall be $123.00.

c. For a hospital qualifying under Section (1)(c) of these rules, the rate is the sum of the amounts for each of the following for which it qualifies:

i. A qualifying hospital—$40.

ii. If it has an average length of stay less than 4.00 days and:

A. More than 150 licensed beds —$20.

B. Fewer than 150 licensed beds—$40.

iii. The eligible hospital with the lowest average length of stay—$15.

iv. It has a CMIUR greater than 65 per centum—$35.

v. It has fewer than 25 total admissions in the safety net hospital adjustment base period—$160.

07/08

d. For a hospital qualifying under subsection (1)(d) the rate shall be $110.

e. For a hospital qualifying under subsection (1)(e), the rate is the sum of the amounts for each of the following for which it qualifies divided by the hospital's total days:

i The hospital that has the highest number of obstetrical care admissions—$30,840.

ii. The greater of:

A. The product of $115 multiplied by the number of obstetrical care admissions.

B. The product of $11.50 multiplied by the number of general care admissions.

07/08

f. For a hospital qualifying under subsection (1)(f), the rate is $56.00.

07/12

g. For a hospital qualifying under subsection (1)(g) of this Section, the rate is $315.50 through December 31, 2014~~June 30, 2012~~. For dates of service on or after January 1, 2015~~July 1, 2012~~, the rate is $210.50.

01/11

h. For a hospital qualifying under subsection (1)(h) of this Section, the rate is $124.50.

07/12

i. For a hospital qualifying under subsection (1)(i) of this Section, the rate is $133.00. For dates of service on or after January 1, 2011 through December 31, 2014~~June 30, 2012~~, this rate shall be increased by $72.00 to $205.00. For dates of service on or after January 1, 2015~~July 1, 2012~~, the rate is $85.50.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: Illinois

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

07/12 XVIII. ~~Excellence in Academic Medicine Payments~~ REPEALED

~~A. The Department shall make payments to certain hospitals providing graduate medical education for Medicaid inpatient admissions occurring on or after July 1, 1996, as specified in this chapter. Payments shall be made to hospitals under the following criteria:~~

~~1. Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive a percentage of the amount available from the National Institutes of Health Account, equal to that hospital's percentage of the total contracts and grants from the National Institutes of Health awarded to Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospitals and their affiliated medical schools during the preceding calendar year as reported to the Department.~~

~~2. Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive payment from the Philanthropic Medical Research Account equal to 25% of all funded grants (other than grants funded by the State of Illinois or the National Institutes of Health) for biomedical research, technology, or programmatic development received by the Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital during the preceding calendar year as reported to the Department.~~

~~3. Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive payment from the Market Medical Research Account equal to 20% of the funding for the project, if, based upon submission of information to the Department, the hospital:~~

~~a. Contributes 40% of the funding, that is at least $100,000, for a biomedical research or technology project or a programmatic development project, and~~

~~b. Obtains contributions from the private sector equal to 40% of the funding for the project.~~

~~B. No hospital receiving payments from the Medical Research and Development Fund shall receive more than 20% of the total amount appropriated to the Fund, except that total payments from the fund to the primary teaching hospitals affiliated with the Southern Illinois University School of Medicine in Springfield, considered as a single entity, may not exceed the product of:~~

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

~~1. One-sixth of the total amount available for distribution from the Medical Research and Development Fund, and~~

~~2. The quotient of total National Institutes of Health grants or contracts awarded to the Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals in the previous calendar year divided by $8,000,000.~~

~~C. The Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals located in Springfield, considered as a single entity, shall be deemed to be a Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital and for the purposes of calculating payments under Sections A and B. Payments under Sections A and B made to the Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals located in Springfield, shall be made to, and divided equally between, the primary teaching hospitals in Springfield.~~

~~D. Payments shall be made to Qualified Academic Medical Center Hospitals for up to three Qualified Programs in any given year as reported to the Department. Qualified Academic Medical Center hospitals may receive continued funding for previously funded qualified programs rather than receive funding for a new program so long as the number of qualified programs receiving funding does not exceed three. Each hospital receiving payments under this Section shall receive an equal percentage of the Post-Tertiary Clinical Services Fund to be used in the funding of Qualified Programs.~~

~~E. Independent Academic Medical Center Hospitals receiving payments under this Section shall receive an equal percentage of the Independent Academic Medical Center Fund. If a hospital is eligible for funds from the Independent Academic Medical Center Fund, that hospital shall not receive funds from the Medical Research and Development Fund or the Post-Tertiary Clinical Services Fund. If a hospital receives funds from the Medical Research and Development Fund or the Post-Tertiary Clinical Services Fund, that hospital is ineligible to receive funds from the Independent Academic Medical Center Fund.~~

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: Illinois

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

~~F. Payments from funds under this Chapter are made to cover the direct costs associated with providing Medicaid services and shall be made directly to the Qualified Academic Medical Center Hospitals or Independent Academic Medical Center Hospitals due the funds, except any funds due to any primary teaching hospital for the University of Illinois School of Medicine at Rockford and the University of Illinois School of Medicine at Peoria shall be paid to the University of Illinois at Chicago Medical Center, which shall be bound to expend the funds on its affiliated hospitals due the funds. Payment rates from each fund described in this Chapter shall equal the product of:~~

~~1. The total Medicaid general care admissions occurring at a qualifying hospital during the quarter for which a payment is made, multiplied by the product of;~~

~~2. The percentage of grant dollars countable under this Chapter, and the quotient of:~~

~~a. funding available within an account or fund as described in this Chapter, divided by,~~

~~b. total Medicaid general care admissions occurring at a qualifying hospital during the quarter for which a payment is made.~~

~~G. No Academic Medical Center Hospital shall be eligible for payments from the Medical Research and Development Fund unless the Academic Medical Center Hospital, in connection with its affiliated medical school, received at least $8,000,000 in the preceding calendar year in grants or contracts from the National Institutes of Health, except that this restriction does not apply to the entity specified in Section C above.~~

~~H. The rate period for payments under this Chapter shall be made for the 12 month period beginning July 1, 1996, for Qualified Academic Medical Center Hospitals, and July 1, 2001 for Independent Academic Medical Center Hospitals. A qualifying hospital's total annual payments from each fund and account described in this Chapter shall be divided into four equal payments and be made by the later of;~~

~~1. The fifteenth working day after July 1, October 1, January 1, and March 1, or~~

~~2. The fifteenth working day after the Department's receipt of reporting information required under Section J below.~~

~~I. Payments made under this Chapter are for inpatient Medicaid services provided in the 12 month period preceding the rate period.~~

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: Illinois

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

~~J. Qualified Academic Medical Center Hospitals initially identified by the Department as qualifying under any payment criteria of this Chapter must complete and return a survey, developed by the Department, attesting to information required to calculate payments under this Chapter. Failure to complete and submit required information by dates established by the Department will result in forfeiture of payments under this Chapter.~~

~~K. Definitions~~

~~As used in this Chapter, unless the context requires otherwise:~~

1. ~~"Academic Medical Center Hospital" means a hospital located in Illinois which is either under common ownership with the college of medicine of a college or University, or a free-standing hospital in which the majority of the clinical chiefs of service are department chairmen in an affiliated medical school.~~
2. ~~"Academic Medical Center Children's Hospital" means a children's hospital which is separately incorporated and non-integrated into the Academic Medical Center Hospital, but which is the pediatric partner for an Academic Medical Center Hospital and serves as the primary teaching hospital for pediatrics for its affiliated medical school. Children's hospitals which are separately incorporated, but integrated into the Academic Medical Center Hospital are considered part of the Academic Medical Center Hospital.~~
3. ~~"Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means an Academic Medical Center Hospital located in the Chicago Metropolitan Statistical Area.~~
4. ~~Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital means an Academic Medical Center Hospital located outside the Chicago Metropolitan Statistical Area.~~
5. ~~"Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means any Chicago Metropolitan Statistical Area Academic Medical Center Hospital that either directly or in connection with its affiliated medical school receives in excess of $8,000,000 in grants or contracts from the National Institutes of Health during the calendar year preceding the beginning of the State fiscal year; except that for the purposes of Section C of this chapter.~~
6. ~~"Qualified Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means the primary teaching hospital of the University of Illinois School of Medicine at Peoria and the primary teaching hospital for the University of Illinois School of Medicine at Rockford and the primary teaching hospitals for Southern Illinois University School of Medicine in Springfield.~~
7. ~~"Qualified Academic Medical Center Hospital" means a Qualified Chicago Metropolitan Statistical Area Academic Medical Center hospital, a Qualified Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital, or an Academic Medical Center Children's Hospital.~~

~~8. "Independent Academic Medical Center Hospital" means the primary teaching hospital for the University of Illinois School of Medicine at Urbana.~~

~~9. "Qualified Programs" include:~~

~~a. Thoracic Transplantation: heart and lung, in particular,~~

~~b. Cancer: particularly biologic modifiers of tumor response, and mechanisms of drug resistance in cancer therapy.~~

~~c. Shock/Burn: development of biological alternatives to skin for grafting in burn injury, and research in mechanisms of shock and tissue injury in severe injury.~~

~~d. Abdominal transplantation: kidney, liver, pancreas, and development of islet cell and small bowel transplantation technologies.~~

~~e. Minimally invasive surgery: particularly laparoscopic surgery.~~

~~f. High performance medical computing: telemedicine and teloradiology.~~

~~g. Trans-myocardial laser revascularization: a laser creates holes in heart muscles to allow new blood flow.~~

~~h. Pet scanning: viewing how organs function (CT and MRI only allow viewing of the structure of an organ).~~

~~i. Strokes in the African-American community: particularly risk factors for cerebral vascular accident (strokes) in the African-American community at much higher risk than the general population.~~

~~j. Neurosurgery: particularly focusing on interventional neuroradiology.~~

~~k. Comprehensive eye center: including further development in pediatric eye trauma.~~

~~l. Cancers: particularly melanoma, head and neck.~~

~~m. Pediatric cancer.~~

~~n. Invasive pediatric cardiology.~~

~~o. Pediatric organ transplantation: transplantation of solid organs, marrow, and other stem cells.~~

~~p. Such other programs as may be identified by the Department and the Qualified Academic Medical Center Hospital, and approved by the Department, for those programs that meet appropriate biomedical research, technology, or programmatic development standards.~~

07/12 XL Rate Reductions

For dates of service on or after July 1, 2012, all inpatient payment methodologies described in this attachment shall be reduced by 3.5%, for the rates that were otherwise in effect on July 1, 2012, except for payments to Long Term Acute Care Hospitals as defined under Chapter VIII(A)(3) which shall have their reimbursement rates reduced by 3.5% from rates that were otherwise in effect on October 1, 2010. Rates reductions defined in this chapter shall not apply to:

1. Rates or payments for hospital services delivered by a hospital defined as a safety net hospital under Section XV(K)(1) of this attachment.
2. Rates or payments for hospital services delivered by a hospital defined as a Critical Access Hospital that is an Illinois hospital designated by Illinois Department of Public Health in accordance with 42 CFR 485 Subpart F.
3. Rates or payments for hospital services delivered by a hospital that is operated by a unit of local government or state university that provides some or all of the non-federal share of such services.
4. Rates or payments for hospital inpatient services defined in Chapters XXXV through XXXIX.

07/12 XLI Payment Limitations

A hospital that is located in a county of the State in which the Department of Healthcare and Family Services mandates some or all of its beneficiaries of the medical assistance program residing in the county to enroll in a care coordination program, shall not be eligible for any non-claims based payments for which it would otherwise be entitled to receive, unless the hospital is a coordinated care participating hospital no later than August 14, 2012, or 60 days after the first mandatory enrollment of a beneficiary in a coordinated care program. This payment limitation does not apply to inpatient payments defined in Chapters XXII through XXIX, or Chapters XXXV through XXXIX.