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State/Territory Name: IL

State Plan Amendment (SPA) #: 15-014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

FEB 25 2016

Felicia Norwood, 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) 15-014

Dear Ms. Norwood:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-014. Effective July 1, 2015, Illinois seeks to eliminate the Medicaid Facilitation and Utilization payments paid for inpatient services to Illinois hospitals that meet specific requirements.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 15-014 is approved effective July 1, 2015. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Fredrick Sebree, of my staff, at (217) 492-4122 or by e-mail at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

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: 15-0014

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, 2015

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 2015 ($1,000,000)
b. FFY 2016 ~~N/A~~ ($4,000,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 131M13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Page 131M13

10. SUBJECT OF AMENDMENT:
Elimination of the Medicaid Facilitation and Utilization payments

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: Materials submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Felicia F. Norwood

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED: 8/12/15

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: FEB 25 2016

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMC

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)

07/15

2. Rates

a. Hospitals qualifying under subsection 1.a. of this Section will receive the following:

i. If the hospital provided more than 4,000 covered Medicaid days, excluding Medicare crossover days in State fiscal year 2013, as recorded in the Department's paid claims database, the rate is $947.00 for dates of service on or after July 1, 2014 through June 30, ~~2018~~2015. For dates of service on or after July 1, ~~2018~~2015, the rate is $0.00.

ii. If the hospital provided less than 4,000 covered Medicaid days, excluding Medicare crossover days in State fiscal year 2013, as recorded in the Department's paid claims database, the rate is $76.00 for dates of service on or after July 1, 2014 through June 30, ~~2018~~2015. For dates of service on or after July 1, ~~2018~~2015, the rate is $0.00.

b. Hospitals qualifying under subsection 1.b. of Section will receive the following:

i. If the hospital had greater than 100 routine beds as included in the 2012 Cost Report on file with the Department, the rate is $205.00 for dates of service on or after July 1, 2014 through June 30, ~~2018~~2015. For dates of service on or after July 1, ~~2018~~2015, the rate is $0.00.

ii. If the hospital had less than 100 routine beds as included in the 2012 Cost Report on file with the Department, the rate is $59.00 for dates of service on or after July 1, 2014 through June 30, ~~2018~~2015. For dates of service on or after July 1, ~~2018~~2015, the rate is $0.00.

c. Hospitals qualifying under subsection 1.c. of this Section will receive a rate of $390.00 for dates of service on or after July 1, 2014 through June 30, ~~2018~~2015. For dates of service on or after July 1, ~~2018~~2015, the rate is $0.00.

3. Payment for a qualifying hospital shall be the product of the rate as defined in subsection 2. of this Section, multiplied by their SFY 2013 covered days less Medicare crossover days as recorded in the Department's paid claims data (adjudicated through February 21, 2014).