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**State/Territory Name: IL**

**State Plan Amendment (SPA) #: 17-003**

This file contains the following documents in the order listed:


1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

**Financial Management Group**

JUL 31 2017

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) 17-003

Dear Ms. Norwood:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 17-003. Effective April 1, 2017, this SPA makes changes to inpatient reimbursements for hospitals that provided more than 4,000 covered Medicaid days.

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 17-003 is approved effective April 1, 2017. 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,

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<br>FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES | 1. TRANSMITTAL NUMBER<br>17-0003 | 2. STATE:<br>ILLINOIS |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION:<br>Title XIX of the *Social Security Act* (Medicaid) | |
| TO: REGIONAL ADMINISTRATOR<br>CENTERS FOR MEDICARE AND MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE:<br>April 1, 2017 | |

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

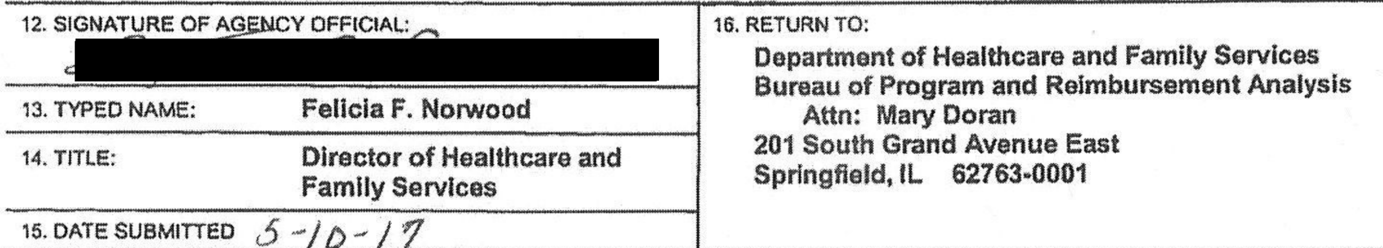
[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

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

| 6. FEDERAL STATUTE/REGULATION CITATION:<br>Section 1902 of the *Social Security Act* | 7. FEDERAL BUDGET IMPACT<br>a. FFY 2017 - $720,000<br>b. FFY 2018 - $1,080,000 |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>Attachment 4.19-A, Page 131M13 | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br>Attachment 4.19-A, Page 131M13 |

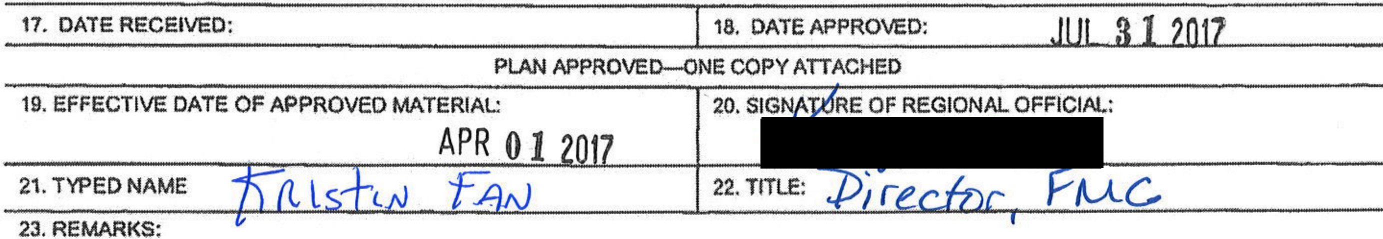
10. SUBJECT OF AMENDMENT:
Changes to hospital inpatient reimbursement

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: | | 16. RETURN TO:<br>Department of Healthcare and Family Services<br>Bureau of Program and Reimbursement Analysis<br>Attn: Mary Doran<br>201 South Grand Avenue East<br>Springfield, IL 62763-0001 |
|---|---|---|
| 13. TYPED NAME: | Felicia F. Norwood | |
| 14. TITLE: | Director of Healthcare and Family Services | |
| 15. DATE SUBMITTED | 5-10-17 | |

FOR REGIONAL OFFICE USE ONLY



| 17. DATE RECEIVED: | 18. DATE APPROVED: JUL 31 2017 |
|---|---|

PLAN APPROVED—ONE COPY ATTACHED

| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>APR 01 2017 | 20. SIGNATURE OF REGIONAL OFFICIAL: |
|---|---|
| 21. TYPED NAME Kristin Fan | 22. TITLE: Director, FMG |

23. REMARKS:

FORM CMS-179 (07/92) *Instructions on Back*

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:

04/17 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, 2015. For dates of service on or after July 1, 2015, the rate is $0.00. For dates of service on or after April 1, 2017 through June 30, 2018, the rate is $738.00. For dates of service on or after July 1, 2018, 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, 2015. For dates of service on or after July 1, 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, 2015. For dates of service on or after July 1, 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, 2015. For dates of service on or after July 1, 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, 2015. For dates of service on or after July 1, 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).