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State/Territory Name: IL

State Plan Amendment (SPA) #: 17-0004

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

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



August 9, 2017

Felicia Norwood, Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Attn: Teresa Hursey

Dear Ms. Norwood:

Enclosed for your records is an approved copy of the following State Plan Amendment.

Transmittal #17-0004 – Enhanced Payments for Outpatient Hospital Services for a Certain
Hospital
– Effective Date: April 1, 2017
– Approval Date: August 7, 2017

If you have any questions, please have a member of your staff contact Courtenay Savage at 312-353-3721 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

/s/

Ruth Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sara Barger, HFS
Kimberley Cox, HFS
Mary Doran, HFS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER 17-0004	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: April 1, 2017	

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 2017 - \$900,000 b. FFY 2018 - \$1,350,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Page 52	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Page 52
10. SUBJECT OF AMENDMENT: Changes to hospital outpatient 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
- 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: Mary Doran 201 South Grand Avenue East 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: May 10, 2017	18. DATE APPROVED: August 7, 2017
PLAN APPROVED—ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2017	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME Ruth A. Hughes	22. TITLE: Associate Regional Administrator
23. REMARKS:	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

31. Hospital Outpatient Assistance Adjustment Payments continued
- b. Outpatient Assistance Adjustment Payments
- Effective for outpatient hospital services on or after July 1, 2014, the following rates are in effect.
- i. For hospitals qualifying under a.i., above the rate is \$850.00-, for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is \$1523.00. For dates of service on or after July 1, 2014, the rate is \$0.00.
 - 07/14 ii. For hospitals qualifying under a.ii., above the rate is \$290 for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.
 - iii. For hospitals qualifying under a.iii., above the rate is \$250.00
 - iv. For hospitals qualifying under a.iv., above the rate is \$336.25
 - v. For hospitals qualifying under a.v., above the rate is \$110.00
 - vi. For hospitals qualifying under a.vi., above the rate is \$200.00
 - 07/14/17 vii. For hospitals qualifying under a.vii., above the rate is \$247.50 for dates of service on or after July 1, 2014 through March 31, 2017. For dates of service on or after April 1, 2017 through June 30, 2018, the rate is \$610.20. For dates of service on or after July 1, 2018, the rate is \$247.50.
 - 07/14 viii. For hospitals qualifying under a.viii., above the rate is \$205 effective July 1, 2014.
 - ix. For hospitals qualifying under a.ix., above the rate is \$65.
 - x. For hospitals qualifying under a.x., above the rate is \$90.00
 - 07/14 xi. For hospitals qualifying under subsection a.xii, the rate is \$47.00 for dates of service on or after July 1, 2010.