**Section 148.140 Hospital Outpatient and Clinic Services**

Effective for dates of service on or after July 1, 2014, unless another date is specified:

a) Fee-For-Service Professional Services Reimbursement. Effective for dates of service on or after July 1, 2020, all fee-for-service hospital outpatient professional services will be reimbursed in accordance with subsection (b)(1) except for end stage renal disease treatment (ESRDT) services, as described in subsection (g).

b) EAPG PPS Reimbursement. Reimbursement under EAPG PPS, described in subsection (c), shall be all-inclusive for all services provided by the hospital, without regard to the amount charged by a hospital. Except as provided in subsection (b)(3), no separate reimbursement will be made for ancillary services or the services of hospital personnel.

1) Outpatient hospital services reimbursed through the EAPG PPS shall include:

A) Surgical services.

B) Diagnostic and therapeutic services.

C) Emergency department services.

D) Observation services.

E) Psychiatric treatment services.

2) Excluded from reimbursement under the EAPG PPS are outpatient hospital services reimbursed pursuant to 59 Ill. Adm. Code 131 and 132, 77 Ill. Adm. Code 2090, and Section 148.330 of this Part.

3) As an exception to the all-inclusive EAPG PPS rate, a separate professional claim may be submitted under a physician's name and NPI for a physician who provided direct patient care. For purposes of this subsection (b)(3), a physician means:

A) A physician salaried by the hospital. Physicians salaried by the hospital do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists; no separate reimbursement will be allowed for those providers.

B) A physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care.

C) A group of physicians with a financial contract to provide emergency department care.

4) Effective for dates of service on or after January 1, 2023, a general acute care hospital that provides more than 500 outpatient psychiatric Medicaid services to persons under 19 years of age in any calendar year prior to the rate year shall be paid a $113 add-on payment. "Rate Year" means the calendar year beginning January 1st, with the first rate year being calendar year 2023.

c) EAPG PPS Payment. The reimbursement to hospitals for outpatient services provided on the same day shall be the product, rounded to the nearest hundredth, of the following:

1) The EAPG weighting factor of the EAPG to which the service was assigned by the EAPG grouper.

2) The EAPG conversion factor, based on the sum of:

A) The product, rounded to the nearest hundredth, of:

i) the labor-related share;

ii) the Medicare IPPS wage index; and

iii) the applicable EAPG standardized amount.

B) The product, rounded to the nearest hundredth, of:

i) non-labor share; and

ii) the applicable EAPG standardized amount.

3) The applicable consolidation factor.

4) The applicable packaging factor.

5) The applicable discounting factor.

6) The applicable policy adjustment factors, as defined in subsection (f), for which the service qualifies.

d) EAPG Standardized Amount. The standardized amount established by the Department as the basis for EAPG conversion factor differs based on the provider type:

1) County-operated Large Public Hospital EAPG Standardized Amount. For a large public hospital, as defined in Section 148.25(a)(1), the EAPG standardized amount is determined in Section 148.160.

2) University-operated Large Public Hospital EAPG Standardized Amount. For a large public hospital, as defined in Section 148.25(a)(2), the EAPG standardized amount is determined in Section 148.170.

3) Critical Access Hospital EAPG Standardized Amount. For critical access hospitals, as defined in Section 148.25(g), the EAPG standardized amounts are determined separately for each critical access hospital such that simulated EAPG payments using outpatient base period paid claim data plus payments as defined in Section 148.456 net of tax costs are equal to the estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.

A) Effective July 1, 2018 through March 8, 2019, simulated EAPG payments are determined using outpatient base period paid claim data plus payments as defined in Section 148.404, net of tax costs equal to estimated costs of outpatient base period claims data.

B) Effective March 9, 2019, simulated EAPG payments are determined using outpatient base period paid claim data results in a 23% increase compared to the sum of the hospital outpatient base period claims allowed amount.

4) Acute EAPG Standardized Amount

A) Qualifying Criteria. General acute hospitals and freestanding emergency centers as defined in 148.25(e) excluding providers in subsections (d)(1) through (d)(3), freestanding psychiatric hospitals, psychiatric distinct part units, freestanding rehabilitation hospitals, and rehabilitation distinct part units.

B) The acute EAPG standardized amount is based on a single statewide amount determined such that:

i) Simulated EAPG payments, without P.A. 97-0689 reductions or policy adjustments defined in subsection (f), using general acute hospital outpatient base period paid claims data, result in approximately a $75 million increase compared to the amount derived in subsection (d)(4)(B)(ii).

ii) The sum of general acute hospital base period paid claims data reported payments and allocated outpatient static payments.

iii) Effective July 1, 2018, in-state hospital simulated EAPG payment using general acute hospital outpatient base period claims data less the rate reductions defined in P.A. 97-0689 results in approximately a $238 million increase inclusive of add-on payments as defined in Section 148.402, compared to the sum of the acute hospital outpatient based period claims allowed amount.

5) Psychiatric EAPG Standardized Amount

A) Qualifying Criteria. Freestanding psychiatric hospitals and psychiatric distinct part units.

B) The psychiatric EAPG standardized amount is based on a single statewide amount, determined such that:

i) Simulated EAPG payments, without policy adjustments defined in subsection (f), using freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data, results in payments approximately equal to the amount derived in subsection (d)(5)(B)(ii).

ii) The sum of freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.

iii) Effective July 1, 2018, in-state hospital simulated EAPG payment using freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period claims data less the rate reductions defined in P.A. 97-0689 results in approximately a $3,870,000 increase compared to the sum of psychiatric hospital outpatient based period claims allowed amount.

6) Rehabilitation EAPG Standardized Amount

A) Qualifying Criteria. Freestanding rehabilitation hospitals and rehabilitation distinct part units.

B) The rehabilitation EAPG standardized amount is based on a single statewide amount, determined such that:

i) Simulated EAPG payments, without P.A. 97-0689 reductions or policy adjustments defined in subsection (f), using freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data, results in payments approximately equal to the annual derived in subsection (d)(6)(B)(ii).

ii) The sum of freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.

iii) Effective July 1, 2018, in-state hospital simulated EAPG payments using freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period claims data less the rate reductions defined in P.A. 97-0689 results in approximately a $57,400 increase compared to the sum of rehabilitation hospital outpatient base period claims allowed amount.

7) Ambulatory Surgical Treatment Center (ASTC) EAPG Standardized Amount. For ASTC's, as defined in 89 Ill. Adm. Code 146.105, the EAPG standardized amount is determined such that simulated EAPG payments using outpatient base period paid claims data are equal to reported payments of outpatient base period paid claims data as contained in the Department's claims data warehouse.

8) Out-of-State Non-Cost Reporting Hospital EAPG Standardized Amount. For non-cost reporting hospitals, the EAPG standardized amount is $362.32, and is not wage adjusted.

e) Discounting Factor. The applicable discounting factor is based on the discounting flags designated by the EAPG grouper under default EAPG settings:

1) The discounting factor will be 1.0000, if the following criteria are met:

A) The service has not been designated with a Bilateral Procedure Discounting flag, Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or

B) The service has not been designated with a Bilateral Procedure Discounting flag and has been designated with a Multiple Procedure Discounting flag by the EAPG grouper under default EAPG settings and the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

2) The discounting factor will be 0.5000 if the following criteria are met:

A) The service has been designated with a Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day; and

B) The service has not been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings.

3) The discounting factor will be 0.7500 if the following criteria are met:

A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and

B) The service has been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

4) The discounting factor will be 1.5000 if the following criteria are met:

A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and

B) The service has not been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or if the Multiple Procedure Discounting flag is present, the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

f) Policy Adjustments. Claims for services by providers that meet certain criteria shall qualify for further adjustments to payment. If a claim qualifies for more than one policy adjustment, then the EAPG PPS payment will be multiplied by both factors.

1) Crossover Adjustment Factor

A) Acute EAPG standardized amounts, as defined in subsection (d)(4), shall be reduced by a Crossover Adjustment factor such that:

i) The absolute value of the total simulated payment reduction that occurs when applying the Crossover Adjustment Factor to simulated EAPG payments, including Policy Adjustments, using general acute hospital outpatient base period paid claims data, is equal to the amount derived in subsection (f)(1)(A)(ii):

ii) The difference of total simulated EAPG payments using general acute hospital outpatient crossover paid claims data, and general acute hospital outpatient crossover paid claims data total reported Medicaid net liability.

B) Crossover Adjustment Factor effective SFY 2015 and 2016 is 0.98912. Effective July 1, 2018, the Crossover Adjustment Factor is defined in (f)(1)(A)(i).

2) If a claim does not qualify for a Policy Adjustment described in subsection (f)(3), the policy adjustment factor is 1.0.

3) High Outpatient Volume Hospital Effective July 1, 2018

A) High Outpatient Volume Hospital is defined as:

i) an Illinois hospital for which the high outpatient volume is at least one and one-half standard deviations above the mean regional high outpatient volume;

ii) an Illinois hospital for which the high outpatient volume is at least one and one-half standard deviations above the mean statewide high outpatient volume;

iii) an Illinois Safety-Net Hospital as defined in Section 149.100; or

iv) an Illinois Small Public Hospital, which is defined as any publicly owned hospital that is not a large public hospital as defined in Section 148.25.

B) Policy adjustment factor is set:

i) For acute care claims such that total expenditures on qualifying claims less the rate reductions defined in P.A. 97-0689 is increased by $79.2 million more than base period qualifying claims allowed amount.

ii) For non-acute care claims to equal the factor in place prior to July 1, 2018.

C) Effective January 1, 2023, and re-determined every subsequent January 1st, qualification criteria for the High Outpatient Volume Hospital designation are:

i) Illinois hospital for which the high outpatient volume is at least two times the mean regional high outpatient volume;

ii) Illinois hospital for which the high outpatient volume is at least one and one-half standard deviations above the mean statewide high outpatient volume;

iii) an Illinois Safety-Net Hospital as defined in Section 149.100; or

iv) an Illinois Small Public Hospital, which is defined as any publicly owned hospital that is not a large public hospital as defined in Section 148.25.

g) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(b) shall be made at the Department's payment rates, as follows:

1) For outpatient services or home dialysis treatments provided pursuant to Section 148.40(c)(2) or (c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate that will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2124 and 413.170 (2010). This rate will be the rate established by Medicare pursuant to 42 CFR 405.2124 and 413.170 (2010).

2) Payment for Non-routine Services. For services that are provided during outpatient or home dialysis treatment pursuant to Section 148.40(c)(2) or (c)(3), but are not defined as a routine service under 42 CFR 405.2163 (1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.50, and 140.75 through 140.481, respectively.

3) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.

4) Effective with dates of service July 1, 2013, hospital and freestanding chronic dialysis centers will receive an add-on payment of $60 per treatment day to the rate described in subsection (g)(1) for outpatient renal dialysis treatments or home dialysis treatments provided to Medicaid recipients under Title XIX of the Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossovers) and excluding services provided under Subpart D: State Chronic Renal Disease Program, as defined in Sections 148.600 through 148.640.

h) Updates to EAPG PPS Reimbursement. The Department may annually review the components listed in subsection (c) and make adjustments as needed. Grouper shall be updated at least triennially and no more frequently than annually.

i) Definitions, as used in this Section:

"Aggregate ancillary cost-to-charge ratio" means the ratio of each hospital's total ancillary costs and charges reported in the Medicare cost report, excluding special purpose cost centers and the ambulance cost center, for the cost reporting period matching the outpatient base period claims data. Aggregate ancillary cost-to-charge ratios applied to SFY 2011 outpatient base period claims data will be based on fiscal year ending 2011 Medicare cost report data.

"Allowed amounts" means the calculated fee schedule amount prior to any adjustment for secondary payer amounts for outpatient base period claims data. If volume in base period data is estimated to differ from rate year volume, then completion factors are applied.

"Consolidation factor" means a factor of 0 percent applicable for services designated with a Same Procedure Consolidation flag or Clinical Procedure Consolidation flag by the EAPG grouper under default EAPG settings.

"Default EAPG settings" means the default EAPG grouper options in 3M's Core Grouping Software for each EAPG grouper version, except where the Department made adjustments.

"Detailed ancillary cost-to-charge ratios" means for each standardized ancillary Medicare cost-center cost-to-charge ratios for each hospital calculated by dividing total costs in Worksheet C, Part 1, Column 5 and Worksheet B, Part 1, Columns 21 and 22 by total charges for each standardized ancillary Medicare cost center in Worksheet C, Part 1, Columns 6 and 7. For all hospitals missing Worksheet C, Part 1, Column 5 data, use Worksheet C, Part 1, Column 3 data. Use aggregate ancillary cost-to-charge ratios as a default when a cost-center specific cost-to-charge ratio is not available or the claim revenue code is all-inclusive ancillary.

"EAPG" means Enhanced Ambulatory Patient Groups, as defined in the EAPG grouper, which is a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. Services provided in each EAPG have similar clinical characteristics and similar resource use and cost.

"EAPG grouper" means the version of the EAPG software, distributed by 3M Health Information Systems, being used by the Department for pricing hospital outpatient services.

"EAPG PPS" means the EAPG prospective payment system as described in this Section.

"EAPG weighting factor" means, for each EAPG, the product, rounded to the nearest ten-thousandth, of:

the national weighting factor, as published by 3M Health Information Systems for the EAPG grouper; and

the Illinois experience adjustment.

"Estimated cost of outpatient base period claims data" means:

Prior to July 1, 2018, the product of:

outpatient base period paid claims data total covered charges;

the critical access hospital's aggregate ancillary cost-to-charge ratio; and

a rate year cost inflation factor.

Effective July 1, 2018, the product of:

Outpatient base period claims data total covered charges;

The critical access hospital's detailed ancillary cost-to-charge ratios; and

A rate year cost inflation factor.

"High outpatient volume" means the number paid outpatient claims described in subsection (b)(1) provided during the high volume outpatient base period paid claims data.

"High volume outpatient base period paid claims data" means:

Prior to July 1, 2018, SFY 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in SFY 2015 and 2016. For subsequent dates of service, the term means the SFY ending 30 months prior to the beginning of the calendar year during which the service is provided.

Effective July 1, 2018, SFY 2015 outpatient Medicaid fee-for-service paid claims data and completed MCO encounter claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in SFY 2019 and 2020; for subsequent dates of service, the most recently available adjudicated 12 months of outpatient paid claims data to be identified by the Department.

"Illinois experience adjustment" means, for the calendar year beginning January 1, 2014, a factor of 1.0; for subsequent calendar years, means the factor applied to 3M EAPG national weighting factors when updating EAPG grouper versions determined such that the arithmetic mean EAPG weighting factor under the new EAPG grouper version is equal to the arithmetic mean EAPG weighting factor under the prior EAPG grouper version using outpatient base period claims data.

"In-state" means all:

Illinois hospitals; and

out-of-state hospitals that are designated a level I pediatric trauma center or a level I trauma center by the Illinois Department of Public Health as of December 1, 2017.

"Labor-related share" means that portion of the statewide standardized amount that is allocated in the EAPG PPS methodology to reimburse the costs associated with personnel. The labor-related share for a hospital is 0.60.

"Mean regional high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(1)(A) through (D), provided by hospitals within a region, based on outpatient base period paid claims data.

"Mean statewide high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(1)(A) through (D), provided by hospitals within the state, based on outpatient base period paid claims data.

"Medicare IPPS wage index" means for in-state providers and out-of-state Illinois Medicaid cost reporting providers, the wage index used for inpatient reimbursement as described in 89 Ill. Adm. Code 149.100. For out-of-state non‑cost reporting providers, the wage index used to adjust the EAPG standardized amount shall be a factor of 1.0.

"Non-labor share" means the difference resulting from the labor-related share being subtracted from 1.0.

"Outpatient base period paid claims data" means:

Prior to July 1, 2018, SFY 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in SFY 2015, 2016 and 2017;

Effective July 1, 2018 through June 30, 2020, for in-state SFY 2015 outpatient Medicaid fee-for-service paid claims data and completed MCO encounter claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in SFY 2019 and 2020.

Effective July 1, 2020:

SFY 2017, or the most recent 12 months of available data as identified by the Department, outpatient Medicaid claims data, for in-state hospitals that are not large public hospitals; and

SFY 2017 and 2018, or the most recent 12 months of available data as identified by the Department, outpatient Medicaid claims data for out-of-state hospitals.

"Outpatient crossover paid claims data" means:

Outpatient Medicaid/Medicare dual eligible fee-for-service and managed care paid claims data, excluding renal dialysis claims and therapy claims, with dates of service from the same time period as outpatient base period claims data.

"Packaging factor" means a factor of 0 percent applicable for services designated with a Packaging flag by the EAPG grouper under default EAPG settings plus EAPG 430 (CLASS I CHEMOTHERAPY DRUGS), EAPG 435 (CLASS I PHARMACOTHERAPY), EAPG 495 (MINOR CHEMOTHERAPY DRUGS), EAPG 496 (MINOR PHARMACOTHERAPY), and EAPGs 1001-1020 (DURABLE MEDICAL EQUIPMENT LEVEL 1-20), and non-covered revenue codes defined in the Handbook for Hospital Services.

"Rate year cost inflation factor" means the cost inflation from the midpoint of the outpatient base period paid claims data to the midpoint of the rate year based on changes in Centers for Medicare and Medicaid Services (CMMS) input price index levels. For critical access hospital rates effective SFY 2015, the rate year cost inflation factor will be based on changes in CMMS input price index levels from the midpoint of SFY 2011 to SFY 2015.

"Region" means, for a given hospital, the rate region, as defined in 89 Ill. Adm. Code [140.Table J](file:///D%3A%5Cmday%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.Outlook%5CWCLMTVN6%5CDraft%20140.Table.J.docx), within which the hospital is located.

"SFY" means State fiscal year.

"Total covered charges" means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMMS 1450), or one of its electronic transaction equivalents.

j) Supplemental Payment. A one-time supplemental payment will be made to a critical access hospital (which is an Illinois hospital designated by the Illinois Department of Public Health in accordance with 42 CFR 485 Subpart F) for outpatient discharges occurring in SFY 2019 for which the outpatient claims were priced and paid under the methodology in subsection (d)(3)(A). The amount of the supplemental payment will be equal to the difference of:

1) The payment amount of each claim calculated using the critical access hospital EAPG standardized amount set to equal a 23% increase in simulated EAPG payments using base period paid claims data set forth in subsection (d)(3)(B); and

2) The payment amount of each claim calculated using the critical access hospital EAPG standardized amount in effect on July 1, 2018.

(Source: Amended at 47 Ill. Reg. 16418, effective November 3, 2023)