

## **V - Medicaid Qualified Practitioner Services – Methodologies for Enhanced Payment Made to Physicians and Practitioners Associated with Academic Medical Centers and Safety Net Hospitals and Upper Payment Calculation**

### **I. Basis of Allowed Enhanced Payment Methodologies**

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that Medicaid payments be “consistent with efficiency, economy, and quality of care.” In meeting these requirements states have flexibility in establishing and updating physician and practitioner payment rates. A number of states extend enhanced payment to practitioners affiliated with academic medical centers or safety net hospitals. With respect to these payments, CMS has determined that the following are economic and efficient payments:

- The Medicare rate
- The average commercial rate
- The Medicare equivalent of the average commercial rate

### **II. Payments based on 100% or Less of the Medicare Physician Fee Schedule**

A state may pay up to 100 percent of the Medicare Physician Fee Schedule (MPFS) without providing a payment demonstration; however, the state must specify in the state plan which version of the MPFS it will implement. The MPFS varies according to site of service (facility and non facility) and geographic locale as defined by Medicare.

- A fill-in box has been in the Demonstration Guidance provided for states to indicate what percentage of the MPFS the state pays.
- Check-off boxes have been provided for states to indicate the MPFS methodology it has chosen to implement for payment.

The formula for physician payment is based on relative value units (RVUs) X geographic adjustment X the conversion factor. Relative value units (RVUs) reflect the relative cost of a physician service; geographic adjustment accounts for geographic variation in the cost of providing physician services; and, the conversion factor converts adjusted RVUs into dollar amounts. The factors used to set the rate are updated periodically.

- States should enter in the fill-box the release date of the RVUs used for the fee schedule.
- Check-off boxes have been provided for states to identify if RVUs vary by site of service, if the facility or non-facility site RVUs are used, if the fee schedule varies by geographic locale identified by Medicare, and if the state will update the fee schedule methodology within a single rate year.
- A fill-in box has also been provided for states to explain how it will update the fee schedule and within what timeframe.

### **III. Overview of Payment up to the Average Commercial Rate (ACR) or the Medicare Equivalent of the ACR**

CMS has approved SPAs that use the following two methodologies for determining targeted enhanced payment to physicians/practitioners affiliated or employed by academic medical centers and safety net hospitals: (1) payment up to the average commercial rate (ACR); (2) payment at the Medicare equivalent of the ACR. States have implemented enhanced payment through the use of an alternate fee schedule and through supplemental payments to the base Medicaid rate. Check off boxes have been provided in the Demonstration Guidance for states to indicate if supplemental payments or an alternate fee schedule is used.

Before an enhanced payment SPA can be approved, a state must demonstrate how it calculated the ACR ceiling. In addition, CMS must review the base Medicaid payment methodology, which is usually a fee for service reimbursement methodology that provides for uniform payments for all providers.

When payment is made up to the ACR states must submit data from the top (generally five) third party payers and provide a full explanation of the data that was extracted from providers' accounts receivable systems. Specifically, the state should compare payment by Medicaid for each billing code to the payment amount allowed by commercial payers for the same services. Data from each of the group practices, hospitals, etc., eligible to receive the supplemental/enhanced payment must be included in the ACR calculation. Billing codes/services not reimbursed by Medicaid must be excluded. Moreover, if the state pays on the basis of local codes rather than HIPAA billing codes then it must provide a code crosswalk to CMS as part of the payment demonstration.

When payment is made up to the ACR, the state must recalculate this upper payment limit annually using updated Medicaid and commercial payment data. For payments up to the Medicare equivalent of the ACR, the percentage does need not be calculated annually, but must be updated at least every three years.

States must exclude from the demonstration volume and payment data associated with FQHCs, RHCs and managed care. Managed care data is included only when a separate fee for service payment has been made to an eligible provider. Non-commercial payers that are not subject to market forces, such as Medicare, must be excluded. Generally, services provided to beneficiaries dually eligible for Medicare and Medicaid must be excluded from the calculation of the payment ceiling. However, in limited circumstances when Medicaid becomes the primary payer for such services as authorized in the state plan, these data may be included in the payment ceiling calculation.

- Check-off boxes have been provided in the Demonstration Guidance for states to indicate if the demonstration is an average commercial rate demonstration (ACR) or a Medicare equivalent of the ACR demonstration and if payment is at a percentage of these rates.
- Check off boxes have also been provided for states to indicate if supplemental payments are made to the base payment methodology or if an alternate fee schedule is used to make enhanced payments.

#### **IV. Average Commercial Rate Demonstrations**

Average commercial rate (ACR) demonstrations show that enhanced payment is made up to the amount of payment allowed by the top (generally five) commercial payers, including copays and deductibles, for each service (by CPT billing code) provided by the practitioners eligible for the enhanced payment.

### Information about Payers

The amount of allowed payment includes reimbursement by the third party payer and any patient liability that together equal the *total* payment for a service allowed by a commercial payer.

- Check off boxes have been provided for states to indicate if data from the top commercial payers or all payers have been included.

The state must confirm that third party data was derived from the billing systems of providers eligible for the enhanced payment. States must be able to clearly demonstrate how the allowed amount was determined under each of the accounts receivable systems of eligible providers.

- A check-off box is included for states to attest that third party payer data came from the billing systems of providers eligible for the enhanced payment.

### Payment Data

The amount of allowed payment by the third party payers includes payments and any patient liability that together equal the total payment for a service allowed by a commercial payer.

- Check off boxes have been included for states to indicate if all copays and deductibles are included, and if data is included for each CPT code for which enhanced payment is made.

### Authorized Billing Codes/Services

The enhanced payment and ACR demonstration must include only billing codes/services that are authorized for payment through the state plan. This means the listing of codes included in the computation of the ACR cannot be more extensive than the listing of billing codes otherwise recognized for payment by the state. For example, if the state does not make a base payment for billing code CPT 99455 (Work related or medical disability examination), then it may not make an enhanced/supplemental payment for that code.

- A check-off box is included for states to provide an assurance that codes for which supplemental or enhanced payments are made have corresponding base payment rates and ACR calculations.

### Dates of Service – In Treatment of ACR Data and Medicaid Volume

A state may implement the ACR in one of three ways: (Method 1) as an alternate enhanced fee schedule paid on a real-time basis; (Method 2) as a supplemental lump sum payment; or, (Method 3) as a supplemental payment up to a defined limit. The choice of methodology will affect how the state identifies the timeframe/dates of service for the data it uses to demonstrate the ACR.

Methods 1 and 2- the state would use Medicaid volume on and after the effective date of the enhanced payment while ACR payment data would likely be derived from a prior period.

Method 3 would likely rely on Medicaid volume and payment data prior to the effective date of the SPA. However, the enhanced payment would be made for services rendered on and after the effective date, up to the payment ceiling. In demonstrating the ACR the state must specify the time periods used to identify payment data and Medicaid volume.

States must use commercial payment data that is no more than two years prior to the effective date of the SPA/year of the ACR demonstration to calculate the ACR. States must recalculate the ACR annually when making ACR-based supplemental enhanced payments. Therefore, while the commercial data used to calculate the ACR may be from prior periods, it can be no older than two years prior to the rate year during which supplemental/enhanced payments will be made.

- A text box has been included in the guidance document for states to identify the time period from which the data used for the ACR calculation is derived

States must submit copies of primary source information for at least one billing code that shows the commercial payment data that was used for the ACR calculation. An example of primary source information is a copy of the invoice that accompanies payment from the third party payer.

- A check-off box is included for states to attest that primary source information for at least one billing code was submitted and a text box is included for states to list the codes submitted.

States are asked to indicate if the Medicaid payment and volume data are derived from the state's MMIS or from another source. Data from MMIS helps to assure that Medicaid payment has been adjusted for dual eligible liabilities and that payment is associated with covered services delivered to Medicaid beneficiaries.

- A check-off box has been included for states to indicate if the source of the Medicaid payment and volume data is the state's MMIS or another source.
- A text box has been included for states to indicate the dates of services of the Medicaid payment and services data from MMIS.

#### Payers not Subject to Market Forces and Managed Care Must Be Excluded

Commercial payers include Medicare, Workers Compensation and any other payer not subject to market forces. Managed care payers that reimburse for services using a capitated rate or sub-capitated rate must be excluded from the demonstration. Managed care payers may be included to the extent that they pay for services on a fee for service basis.

- A check-off box is included for states to denote that data for Medicare, Workers Compensation, and any other payer not subject to market forces are excluded.
- A check-off box is included for states to indicate that capitation or sub-capitation payments made by managed care payers are excluded.
- A check-off box is included to indicate if fee for service payments made by managed care entities is included and a text box is included for states to explain which services are paid in this manner and to identify the authority and state plan location of these fee for service payments.

#### Dually Eligible Beneficiaries

States are asked to indicate if enhanced payments and the demonstration data exclude services provided to beneficiaries who are dually eligible for Medicaid and Medicare. If the enhanced payment includes payments and data for dually eligible beneficiaries, states should document the authority provided for these payments as found in Supplement 1 to Attachment 4.19-B of the state plan and demonstrate how payments and charges for which Medicaid is the primary payer are identified.

- Check-off and text boxes have been provided for states to indicate if payments and data exclude dually eligible beneficiaries and to identify in the state plan the authority for any service payments and how these payments are identified in the demonstration.

#### Eligible Providers and Practitioners

All academic medical centers and/or hospitals that will participate in the enhanced payment should be identified.

- A text box has been provided for states to list all medical centers and/or hospitals by campus, geographic location, or other criteria, participating in the enhanced payment program.

If states are paying providers up to a provider-specific average commercial rate, the demonstration must include separate calculations for each of the providers eligible to receive the enhanced/supplemental payment.

- Check-off boxes have been included for states to indicate if provider-specific payments are made and if the demonstration includes separate calculations for these provider-specific payments.

Services of non-physician practitioners who are enrolled, qualified Medicaid providers also can be targeted for increased payment, subject to an ACR demonstration.

- A text box has been provided for states to identify the practitioners eligible for higher payment.
- A check-off box has been provided for states to indicate that all data are included in the demonstration for all of the types of practitioners whose services are eligible for the enhanced/supplemental payment.

Enhanced provider payments are made for professional provider services and should exclude non-professional services. Therefore, the ACR demonstration must exclude non-professional services.

- States should indicate in the check-off box if non-professional services have been excluded from the data.

As part of the payment demonstration, the state must explain how it identified the services of eligible providers that qualify for the supplemental/enhanced payment. For example, if a state identified providers on the basis of their rendering provider number and or billing number, this must be described.

- A text box has been provided for states to describe the manner in which eligible providers' services were identified.

#### Radiology, Clinical Diagnostic Laboratories, and Anesthesia Services

A physician services payment demonstration should exclude the technical component of radiology services, as this is not a professional service. Radiology services as found in the 70000 CPT series can include both a professional and non-professional (or a technical) component that may be paid either separately or through a bundled rate. The technical component is meant to pay for materials used to perform a radiology procedure and is denoted in the billing code with a "TC" modifier. The professional component recognizes physician work associated with reading radiographs. Only the professional component of radiology services should be included in the demonstration if an enhanced payment is made for radiology services.

- States should indicate in the check-off box if the technical component of radiology services has been excluded from the demonstration.

States should inform CMS if the demonstration includes any clinical diagnostic laboratory (CDL) services. Clinical diagnostic laboratory services as found in the 80000 CPT coding series are mostly non-physician services and are subject to an upper payment limit at section 1903(i)(7) of the Act. The upper payment is limited to the amount Medicare would pay on a per test basis or a per code basis for a bundled/panel of tests. In cases where CDL services are professional services, these data can be included in the ACR demonstration, however enhanced payment for these services cannot exceed the upper payment limit required by section 1903(i)(7) of the Act.

- A check off box has been included for states to indicate if CDL services are included in the demonstration and if they are paid at or below the Medicare rate on a per test basis.
- A text box has been provided for states to list any CDL codes that are included in the demonstration.

If the demonstration includes anesthesia services, states must explain if Medicaid uses the same units of service to determine the payment rate as commercial payers and/or Medicare. If Medicaid payment does not directly crosswalk to these payers, states must explain how the methodology addresses any differences in payment methodologies.

Note on anesthesia payment: Medicare (and other third party providers) reimburses providers a base amount for each service/CPT code in addition to an incremental amount for the amount of time used to deliver the service. CMS has found that states do not necessarily measure time in the same way that Medicare does. Additionally, if states included services of CRNA's (certified registered nurse anesthetists) or other non-physicians rendering anesthesia, those services will be denoted by CPT codes with modifier "QX" and are usually reimbursed by both commercial payers and Medicaid at a percentage of the fee paid to physicians. These differences in payment must be taken into account by the state in demonstrating its payment methodology.

- A text box has been provided for states to explain if the Medicaid payment for anesthesia services directly crosswalks to Medicare payment, to indicate if Medicaid pays in the same time units of service as Medicare, and how states address any differences between Medicaid and Medicare payment methodologies in the demonstration.

### **Calculation of the Average Commercial Payment**

The average commercial rate (ACR) is used to establish a payment ceiling for supplemental payments to qualified, enrolled Medicaid practitioners. In order for CMS to evaluate if these payments comport with section 1902(a)(30)(A) of the Act, which specifies that payments must be efficient and economic, states must submit, *in spreadsheet form*, a detailed calculation of the average commercial rate (ACR) or the Medicare equivalent of the ACR for all procedure codes eligible for payment to demonstrate how the upper limit of payment was established for practitioner supplemental payments. In addition, states must submit a copy of the invoices which accompanies payment from all of the top commercial payers to document how it identified the allowed amount for at least one code included in the demonstration. The names of the commercial payer(s) on the invoice can be masked however the payment amounts should be evident.

The steps below describe the methodology that states can use to calculate the ACR to establish an upper payment ceiling for practitioner supplemental payments.

**Step 1: Compute Average Commercial Rate**

For each procedure code (e.g., CPT or HCPCS code) for which enhanced payment will be made, states must collect payment data from eligible providers’ billing systems and compute the average commercial rate paid by billing code by the top (generally five) commercial third party payers (TPPs) or all commercial TPPs during a defined base period for these procedure codes.

The top payers are those which pay the most to the practices eligible for the supplemental payment, in total, not by CPT, as opposed to the top TPPs to whom the practices submit charges. Excluded from the calculation are data from Medicare, Workers’ Compensation and other non commercial payers that are not subject to market forces. Managed care payers may be included to the extent that they pay for services on a fee for service basis. Managed care payers that reimburse for services using a capitated or sub-capitated amount may not be included.

Note that commercial insurers almost always pay an allowed amount for a service rather than pay on the basis of the providers’ charges. In most instances the commercial insurer and patient share in payment up to the allowed amount. Regardless of patient liability for any copayment or deductible, CMS permits calculation of the average commercial rate using the allowed amount to represent payment by the commercial payer.

Example of calculating the ACR

<u>Procedure code</u>	<u>99201</u>	<u>99215</u>
1) Commercial payer 1 rate =	\$100.00	\$150.00
2) Commercial payer 1 rate =	\$75.00	\$75.00
3) Commercial payer 1 rate =	\$50.00	\$94.00
4) Commercial payer 1 rate =	\$89.00	\$60.00
5) Commercial payer 1 rate =	\$20.00	\$65.00
6) Average commercial rate ((sum 1:5)/5) =	\$66.80	\$88.80

**Step 2: Calculate the Payment Ceiling**

An aggregate Medicaid payment ceiling must be calculated. For each of the billing codes for which practitioner supplemental payments are to be made, the ACR for each code is multiplied by Medicaid volume to calculate the amount that would have been paid using the average commercial rate. The resulting amount is the payment ceiling per code; the total payment ceiling is calculated by summing the product of all codes per provider for the codes for which supplemental payment is to be made.

To calculate the Medicaid payment ceiling, multiply the average commercial rate as determined in Step 1 by the number of claims recorded in MMIS for each procedure code that was rendered to Medicaid beneficiaries by eligible practitioners. Add the product for all procedure codes. This total represents the supplemental/enhanced payment ceiling. Please note that total payments, Medicaid base payments plus supplemental payment, can be made only up to a maximum of this ceiling amount.

Example of calculating the Medicaid payment ceiling:

- A. Multiply the average commercial rate as determined in Step 1 by the number of claims recorded in MMIS for each procedure code that was rendered to Medicaid beneficiaries by eligible practitioners during the base period used for Step 1.

Example of calculating the Medicaid payment ceiling:

<u>Procedure code</u>	<u>99201</u>	<u>99215</u>
1) ACR per code =	\$66.80	\$88.80
2) Medicaid volume per code =	100	200
3) Payment ceiling per code (1 X 2) =	\$6,680	\$17,760

- B. Calculate the total Medicaid payment ceiling by summing the product of each procedure code.

4) Total payment ceiling (sum of 3) = \$6,680 + \$17,760 = \$24,440

**Payment ceiling equals the sum for all CPTs of: (average commercial payment per CPT Code) X (Medicaid volume per CPT Code as reported in MMIS)**

**Supplemental payment equals the payment ceiling less Medicaid payment *in total* from MMIS.**

Supplemental payments or payments made using an enhanced fee schedule may not, in the aggregate, exceed this reimbursement ceiling. A State may make payment up to this ceiling either by adjusting its fee schedule to equal the amount per billing code as calculated by the ACR or by making supplemental payment in addition to its regular fee schedule reimbursement.

- Check-off boxes have included for states to indicate if supplemental/enhanced payment is made on a per code payment ceiling basis or is based on the aggregate (sum of the per code payment ceiling) basis.

If the average commercial rate methodology is used to determine supplemental payment, the ACR amount for each billing code must be calculated/updated annually to determine payment ceiling.

- A text box has been provided for states to indicate the date of the last ACR demonstration.

**V. Medicare Equivalent of the Average Commercial Rate Demonstrations**

States may make enhanced/supplemental payments using the Medicare equivalent of the average commercial rate (ACR). This methodology establishes a ratio of commercial payment to Medicare payment to calculate the supplemental/enhanced payment. This ratio is a single statistic that is multiplied by the Medicare payment for all procedure codes eligible for supplemental payment. The supplemental payment ceiling equals the enhanced payment amount multiplied by the Medicaid volume incurred for each eligible procedure code.

Calculation of the Average Commercial Payment

To calculate the payment ceiling for supplemental payments to qualified, enrolled Medicaid practitioners using the Medicare equivalent of the ACR methodology, the ACR is first calculated. (Please see the instructions above for how to calculate the ACR.)



**Step 1: Calculate the Average Commercial Rate Paid by Commercial Payers per Provider**

States should follow the narrative directions for calculating the ACR for each provider for whom the supplemental payment is made. All of the requirements for calculating the ACR specified above must be adhered to under this methodology. The ACR per procedure code is needed in this methodology to calculate the Medicaid payment ceiling (Step 2), which is required for the calculation of a Medicare equivalent of the ACR single statistic (Step 3). This single statistic is used to calculate enhanced payment per procedure code (Step 4).

**Step 2: Calculate the Medicaid Payment Ceiling**

An aggregate Medicaid payment ceiling must be calculated. For each of the billing codes for which practitioner supplemental payments are to be made, the ACR for each code is multiplied by Medicaid volume to calculate the amount that would have been paid using the average commercial rate. The resulting amount is the payment ceiling per code; the total payment ceiling is calculated by summing the product of all codes per provider for the codes for which supplemental payment is to be made.

- A. Multiply the average commercial rate as determined in Step 1 by the number of claims recorded in MMIS for each procedure code that was rendered to Medicaid beneficiaries by eligible practitioners during the base period used for Step 1.

Example of calculating the Medicaid payment ceiling:

<u>Procedure code</u>	<u>99201</u>	<u>99215</u>
1) ACR per code =	\$66.80	\$88.80
2) Medicaid volume per code =	100	200
3) Payment ceiling per code (1 X 2) =	\$6,680	\$17,760

- B. Calculate the total Medicaid payment ceiling by summing the product of each procedure code.  
  
4) Total payment ceiling (sum of 3) = \$6,680 + \$17,760 = \$24,440

**Step 3: Calculate the Average Commercial Rate as a Percentage of Medicare**

Multiply the Medicare rate per procedure code by the number of claims recorded in MMIS for each procedure code that was rendered to Medicaid beneficiaries during the base period used for Step 1. Add the product for all procedure codes. This sum represents total Medicare payment that would have been received. Divide the total Medicaid payment ceiling by total Medicare payments. This ratio expresses the ACR as a percentage of Medicare.

- C. Multiply the Medicare rate by the procedure codes in A. by the number of claims for those procedure codes.
- D. Calculate the average commercial rate as a percentage of Medicare by summing the results for all codes in A., summing the results for all codes in B., and dividing A. by B. This ratio is multiplied by the Medicare rate for any covered procedure code to calculate the enhanced payment per procedure code and takes into account base and supplemental payments.

Example of calculating the average commercial rate as a percentage of Medicare:

<u>Procedure code</u>	<u>99201</u>	<u>99215</u>
5) Medicare rate per code =	\$55.00	\$60.00
6) Medicaid volume per code (2) =	100	200
7) Medicare payment per code =	\$5,500	\$12,000

- 8) Sum the payment ceiling in (3) for each code and the estimated Medicare payment in (7) for each code.

Total Medicaid Payment Ceiling =	\$6,680 + \$17,760 = \$24,440
Total Medicare Payment =	\$5,500 + \$12,000 = \$17,500

- 9) Calculate the Medicare equivalent of the ACR single statistic. Divide the sum total of (3) by the sum total of (7) to calculate the average commercial rate as a percentage of Medicare.

Total Medicaid payment ceiling divided by total estimated Medicare payment (3 divided by 7) =  $\$24,400 / \$17,500 = 139.66\%$

This single ratio (Medicare equivalent of the ACR) is applied to the Medicare rates for reimbursable Medicaid practitioner services to determine the enhanced Medicaid payment. The application of the ratio results in enhanced payment that includes both the regular base payment and supplemental payment.

Note: The ratio from Step 3 does not have to be computed annually but should be rebased/updated at least every three years.

**Step 4: Calculate total maximum supplemental payment**

The total maximum supplemental payment per provider is calculated by multiplying the Medicare equivalent of the ACR (the single statistic) by the Medicare rate for each eligible procedure code, summing the product of each code, and subtracting MMIS payments per eligible procedure code for which supplemental payment is to be made. The total supplemental payment for each eligible provider can be made only up to this net amount.

Enhanced payment equals the single statistic multiplied by the Medicare rate per code less Medicaid base payment.

Example of total maximum supplemental payment

- A. Multiply each provider's individual Medicare equivalent of the ACR single statistic by the eligible procedure codes to determine the enhanced rate per code.

<u>Procedure code</u>	<u>99201</u>	<u>99215</u>
1) Medicare rate per code =	\$55.00	\$60.00
2) Medicare equivalent of the ACR =	139.66%	139.66%
3) Enhanced rate (1 X 2) =	\$76.81	\$83.80

B. Multiply the volume per code reported in MMIS for each eligible provider by the enhanced rate per code.

<u>Procedure code</u>	<u>99201</u>	<u>99215</u>
4) Enhanced rate (3) =	\$76.81	\$83.80
5) Provider volume reported in MMIS =	100	200
6) Enhanced payment per code =	\$7,681	\$16,759

Because the aggregate Medicare equivalent of the ACR is used, the total enhanced payment (the sum of the enhanced payment per code) should equal the total Medicaid payment ceiling. A checkbox has been included for states to indicate that the sum of the enhanced payment per code is equal to the total Medicaid payment ceiling.

C. Report Medicaid payments from MMIS per procedure code per eligible provider.

<u>Procedure code</u>	<u>99201</u>	<u>99215</u>
7) Provider's payments reported in MMIS	\$4,125	\$9,000

D. Calculate maximum total supplemental payment amount.

<u>Procedure code</u>	<u>99201</u>	<u>99215</u>
8) Enhanced payment per code (6) =	\$7,681	\$16,759
9) Provider's payments reported in MMIS =	\$4,125	\$9,000
10) Maximum supplemental payment (6 minus 7) =	\$3,556	\$7,759

11) Grand total net supplemental payment (sum of 10) = \$11,315

Note: The total supplemental payment that can be paid per provider is the amount calculated in D. 11. Supplemental payments are calculated separately per provider based upon each provider's individual ACR calculation, MMIS volume, Medicare equivalent of the ACR ratio, and MMIS payments. A checkbox has been included for states to attest that all provider supplemental payments are a maximum of the net supplemental payments calculated in D. 11.