No.	UPL IMD Guidance Questions in MACFin System
Section I: UPL Demonstration Overview:	
1	Are there any significant changes to the prior year UPL methodology?
2	Does the UPL demonstration align with your state fiscal year? Does the UPL demonstration trend data from the previous UPL demonstration submission or does it contain new data?
3	If using trended data, please specify which data variables are trended.
4	Does the UPL demonstration include a full 12 months of data for each provider?
5	Is the beginning date of the data more than 2 years from the beginning date of the UPL demonstration period?
6	Has the provider count (providers enrolled in the Medicaid program and included in the UPL demonstration) changed from the previous UPL demonstration?
6a	Please explain the changes, including any new providers, closed providers, or mergers. Please also cite the source of this data.
6b	Please list any changes in the provider category designations (SGO, NSGO, and Private).
7	Indicate the percentage of managed care and FFS in the state's Medicaid program overall and also for IMD services.
Section II: The source of the UPL Medicare Equivalent Data is:	
1	What source is used to obtain the Medicare Equivalent data?
1a	If Other, please fully explain the date source(s) and how the data is used.
1b	Does the Medicare payment data represent gross reported payment, or are adjustments made to the data to capture the net payment?
2	How the price-based demonstration adjusts for differences in Medicare and Medicaid patient acuity?
3	What is the time period of the data?
Section III: The State uses the Cost Report References below:	
1	Indicate which cost report is used and which Worksheets, Parts, Columns, and Lines are used to populate the data.
2	Does the Medicare payment data represent gross reported payment, or are adjustments made to the data to capture the net payment?

Section IV: The State applies the Medicaid charge or day data to the Medicare per diem amounts as des

1 Are the Medicaid covered charges and days from paid claims reported from MMIS?

2 Do the dates of service for the Medicaid charge and day data [variable 300.1 and variable 300.2] match the dates of services from the Medicare cost report data [variable 200.1 and variable 200.2]?

3 Does the state only include Medicaid charges from in-state Medicaid providers residents?

4 Does the charge data exclude crossover claims?

5 Are physicians and other professional service charges included?

Section V: The UPL demonstration applies Medicaid payment data as follows:

1 Are Medicaid base payment data reported from the MMIS?

2 Are the dates of service for the Medicaid payment data consistent with the Medicaid charge/day data and the IMD cost reporting period?

3 Does the Medicaid payment data include ALL base and supplemental payments to IMD providers?

4 Do Medicaid payment data exclude crossover claims?

5 Is the Medicaid payment reported gross or net of the primary payer payments, deductibles, and co-pays?

6 Describe how Medicaid payment rate changes between the base period and the UPL period are accounted for in the demonstration?

6a Are all adjustments related to approved SPAs between the Medicaid data base period and UPL demonstration period accounted for in the demonstration?

Section VI: The State trends or adjusts the UPL data, as follows:

1 Does the state trend the UPL for inflation?

1a Is the inflation factor trend applied from mid-point to mid-point in order to most accurately project future experience?

2 Does the state trend the UPL for volume/utilization?

3 Are there any additional trends or factors for the UPL (not for the Medicaid payments) that are used in the UPL demonstration and their application?

4 Does the state apply a claims completion factor (when a state does not have a full year of data for the trending factors) to the charge or day data?

5 Does the state apply a claims completion factor to the payment data?

5a If Yes, is the claims completion factor equally applied to the payment and Medicaid charge or day data used in computing the Medicare UPL (all data in the demonstration should be for a full year)?

Section VII: The state UPL data demonstration is structured as follows:

1 Explain any significant increases or decreases in the UPL Gap from the prior year's UPL demonstration for each applicable provider category (SGO, NSGO, and Private).

2 Does the demonstration include all IMDs that receive payments under Medicaid?

3 Does the UPL demonstration only include in-state IMDs?

4 Are provider taxes included and/or adjusted for in the UPL data (variable 401)?

Original Document (PRA completed in January 2021)

I. The Basis of the UPL Formula is:
0 Cost-Based Demonstration (e.g. Cost-to-charge ratio X Medicaid covered I/P charges) or
0 Payment-Based Demonstration (e.g. Payment-to-charge ratio X Medicaid covered I/P charges)
0 Medicare DRG (Acuity-Adjusted Price-Based Demonstration)

0 Other (please describe below): Open text box

0 Other (please describe below): Open text box
Please provide a general description of the formula: Open text box

Please provide a general description of the formula: Open text box

0 Other (please describe below): Open text box

0 Other (please describe below): Open text box
0 Other (please describe below): Open text box

0 Other (please describe below): Open text box

II. The source of the UPL Medicare Equivalent Data is:
0 The Medicare Cost Report (CMS 2552-96 or 2552-10)
0 Filed
0 Settled
0 Please explain all other data source(s) used in the UPL calculation.

New question

Please explain the pricer factors and how they tie to what Medicare has established for the providers in the base year. Also explain how mother and baby days are handled.

What is the time period of the data?
Base year data: _____
Rate year data: _____

III. The State uses the Cost Report References below:
Cost-Based Demonstration (e.g. Ancillary Cost-to-Charge Ratio and Room and Board per Diems):
0 Worksheet B
0 Worksheet C
0 Worksheet D-1
Describe which columns and lines that are used to determine the cost-to-charge ratios and, if applicable, the hospital routine per diem amounts used in the cost-based UPL.

Payment-to-Charge Demonstration (Payment to Charge Ratio) use:
0 Worksheet E, Part A (Payments) / Worksheet D-4 (Charges)
Describe which worksheets, columns and lines that are used to determine the Medicare payments and charges to calculate the payment-to-charge ratio(s).

cribed below:

The Medicaid covered charges/days/discharges are from paid claims reported from the MMIS. 0 The Medicaid covered charges/days/discharges are from another source.
Other source: ¬¬¬¬¬¬_____.

Do the dates of service for the Medicaid charge/day/discharge data match the dates of services from the Medicare cost report data?
If no, please explain.

Does the state only include Medicaid charges from in-state Medicaid residents?
0 Yes
0 No

No change

No change

Medicaid base payment data is reported from the MMIS.
0 Yes
0 No
If the source of the payment data is a different source, please explain

Medicaid payment data includes ALL base and supplemental payments to inpatient hospital providers. Note: any reimbursement paid outside of MMIS should also be included (e.g. Organ Acquisition payments, GME payments, etc.). Within the demonstration the base and supplemental payments must be separately identified.
0 Yes
0 No
Please explain payments that are made outside of the MMIS.

Medicaid payment data exclude crossover claims.
0 Yes
0 No

Is the Medicaid payment reported gross or net of primary care payments, deductibles and co-pays?
0 Gross
0 Net

No change

Does the dollar amount of payments for the UPL base period equal the "claimed" amounts on the CMS-64, Medicaid Expenditures report for the UPL time period?
0 Yes
0 No If no, please provide a reconciliation and explanation of the difference?

The state trends the UPL for inflation
0 Yes
0 No
Explain the trending factor and its source. ¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬

Is the inflation trend applied from "mid-point to the mid-point" in order to most accurately project future experience?
0 Yes
0 No

The state trends the UPL for volume/utilization.
¬¬¬¬¬¬¬0 Yes
0 No Explain the volume/utilization adjustment, including: how will it assure the UPL does not over or understate the volume of Medicaid inpatient hospital services provided in the rate year, how it is applied and that it is applied consistently to the Medicare equivalent and Medicaid payment data:

Please explain all additional trends or factors that are used in the demonstration and their application:

Does the state apply a claims completion factor to the charge/day/discharge data?
0 Yes
0 No
Please explain the claims completion factor and its application:

No change

Is the claims completion factor equally applied to the payment and Medicaid charge/day/discharge data used in computing the Medicare UPL?
0 Yes
0 No
Please explain the claims completion factor and its application:

New question

New question

New question

New question

Explanation	Burden Change
CMS folded the Old Guidance & Instructions documents into 1 online form that asks questions that before were open text boxes that states had to fill in to explain their methodology. Here the crosswalk includes any changes.	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No

	No
	No
	No
	No
This question was removed as no longer relevant given the other questions asked.	No
	No
	No
	No
	No
This question was removed as no longer relevant given the other questions asked.	No
	No
	No
	No
	No
	No
	No

	No
	No
	No
Required to confirm if there are any discrepancies in the adjustsments to Medicaid payments in the periods of the base payments and UPL demonstration period.	No
	No
These are IMD specific questions that clarify UPL IMD submissions from inpatient hospital submissions	No
These are IMD specific questions that clarify UPL IMD submissions from inpatient hospital submissions	No
These are IMD specific questions that clarify UPL IMD submissions from inpatient hospital submissions	No
These are IMD specific questions that clarify UPL IMD submissions from inpatient hospital submissions	No

No.	UPL ICF/IID Guidance Questions in MACFin System
Section I: UPL Demonstration Overview	
1	Are there any significant changes to the prior year UPL methodology?
2	Does the UPL demonstration align with your state fiscal year?
3	Does the UPL demonstration trend data from the previous UPL demonstration submission or does it contain new data? If using trended data, please specify which data variables are trended.
4	Does the UPL demonstration include a full 12 months of data for each provider?
5	Is the beginning date of the data more than 2 years from the beginning date of the UPL demonstration period?
6	Has the provider count changed from the previous UPL demonstration?
6a	Please explain the changes, including any new providers, closed providers, or mergers. Please also cite the source of this data.
6b	Please list any changes in the provider category designations (SGO, NSGO, and Private).
7	Indicate the percentage of managed care and FFS in the state's Medicaid program overall and also for ICF/IID services.
Section II: Source of the UPL Medicare Equivalent Data is:	
1	What is the basis of the UPL formula?
2	What is the time period of the data used in the demonstration, including the beginning and ending dates?
3	Is the data the most recently available to the state?
Section III. Medicare cost comparison is verified as described below:	
1	What is the source of the UPL Medicare equivalent data?
Cost Report Development (Sub-section)	
1	Does the cost report recognize allowable and non-allowable costs in accordance with Medicare Cost Principles in 42 CFR 413 and 45 CFR 75?

2	Has the Centers for Medicare and Medicaid Services (CMS) reviewed the cost report?
3	Do providers submit the cost reports to the State Medicaid agency annually?
4	Is the cost report audited by the state agency or through an independent audit?

Cost Finding Methodology (Sub-section)

1	Please describe the cost identification and allocation process (including the recognized direct costs, treatment of indirect cost, all allocation methods used to determine the costs related to Medicaid services). If the cost identification and allocation process are different from Medicare Cost Principles then please explain.
2	Are indirect/overhead costs and direct service costs separately identified on the cost report?
3	Are both routine and ancillary service costs identified on the cost report?
4	Are ancillary service costs separately identified on the cost report?
4a	Please describe how the routine and ancillary costs are reported in the cost report and how they are treated for the purpose of determining Medicaid ICF/IID cost.
5	Are Central Office or related entity costs allocated to the ICF/IIDs?
5a	Please describe how Central Office or related entity costs are identified in the cost report and are allocated to represent actual Medicaid incurred cost.

Application of Medicaid days to per diem cost (applies to both state-developed cost report an

1	Does the cost report arrive at an ICF/IID cost per diem for each facility and apply Medicaid days to the per diem?
2	For the determination of cost used for the per diem, is cost exclusive or inclusive of cost associated with non-certified beds?
3	Have the per diem cost and/or Medicaid rates been adjusted for low occupancy?
4	Is the per diem ICF/IID cost inclusive of all routine and ancillary services?
5	Does the state use paid claims data from the MMIS as the source of the Medicaid days?

6	Are the Medicaid days used in the UPL calculation from the same period as the cost report period?

Section IV. Source of the Medicaid Payment Data

1	Are Medicaid base payment data reported from the MMIS?
2	Does the Medicaid payment data include ALL base and supplemental payments to ICF/IID providers?
3	Are the dates of service for the Medicaid payment data consistent with the Medicaid cost reporting period?
4	Where the state makes Medicaid payment outside of Attachment 4.19-D for other services furnished to ICF/IID residents, are these Medicaid payments excluded from the UPL demonstration?
4a	If applicable, please explain any excluded Medicaid payments that are made outside of 4.19-D. Also please explain how their related costs are excluded from the computation of the cost UPL.
5	Does the Medicaid payment data exclude crossover claims?
6	Is the Medicaid payment reported gross or net of primary payer payments, deductibles, and co-pays?
7	Describe how Medicaid payment rate changes between the base period and the UPL period are accounted for in the demonstration.
7a	Are all adjustments related to approved SPAs between the Medicaid data base period and UPL demonstration period accounted for in the demonstration?

Section V. The state trends and adjusts the UPL Data, as below:

1	Does the state trend the UPL for inflation?
1a	Does the state exclude capital costs from the trending?
1b	Is the inflation trend applied from “mid-point to the mid-point” in order to most accurately project future experience?
2	Does the state trend the UPL for volume/utilization?

3	Are there any additional trends or factors for the UPL (not for the Medicaid payments) that are used in the UPL demonstration and their application?
4	Does the state apply a claims completion factor (when a state does not have a full year of data for the trending factors) to the charge or day data?
5	Does the state apply a claims completion factor to the payment data?
5a	If Yes, is the claims completion factor equally applied to the payment and Medicaid charge or day data used in computing the Medicare UPL (all data in the demonstration should be for a full year)?

Section VI. The state UPL data demonstration is structured as follows:

1	Explain any significant increases or decreases in the UPL Gap from the prior year's UPL demonstration for each applicable provider category (SGO, NSGO, and Private).
2	Does the demonstration include all ICF/IID facilities that receive payments under Medicaid?
3	Does the demonstration only includes in-state ICF/IIDs?
4	Are provider taxes included and/or adjusted for in the UPL data (variable 401)?

No Question

No Question

No Question

No Question

No Question

No Question

No Question

No Question

No Question

No Question

Original Document (PRA completed in January 2021)

New Question

New Question

New Question

New Question

New Question

New Question

New Question

New Question

New Question

I. The basis of the UPL formula is:
☐ Medicaid Cost Demonstration Using Medicare Cost Finding Principles
☐ Other (please describe below):

What is the time period of the data used in the demonstration, including the beginning and ending dates?
Base year data: _____
Rate year data: _____
No change

The source of the UPL Medicare equivalent data is:
☐ State Developed Cost Report using Medicare Cost Identification Principles
☐ Modified Medicare Skilled Nursing Facility Cost Report (CMS 2540)

Cost report development:
Does the cost report recognize allowable and non-allowable costs in accordance with Medicare Reimbursement Principles (PRM-15-1) and OMB Circular A-87?
☐ Yes
☐ No

No change

No change

No change

If the state uses a modified Medicare SNF report, does the state capture the same types of allowable costs as reported on the Medicare SNF cost report?

☐ Yes
☐ No
☐ Not applicable

If no, has the state documented and explained the cost category discrepancies?
Please explain all discrepancies and modifications to the SNF template.

Cost Finding Methodology

Please describe the cost identification and allocation process (including the recognized direct costs, treatment of indirect cost, all allocation methods used to determine the costs related to Medicaid services).

Are indirect/overhead costs and direct service costs separately identified on the cost report?

☐ Yes
☐ No

No change

No change

No change

Are Central Office or related entity costs allocated to the ICF/IDs?

☐ Yes
☐ No

No change

ıd Medicare-based cost report) (Sub-section)

Does the cost report arrive at an ICF/ID cost per diem for each facility and apply Medicaid days to the per diem?

☐ Yes
☐ No

No change

Has the per diem cost and/or Medicaid rates been adjusted for low occupancy?

☐ Yes
☐ No

No change

No change

No change

Medicaid base payment data is reported from the MMIS.
☐ Yes
☐ No
If the source of the payment data is a different source, please explain:

Medicaid payment data includes ALL base, add-ons, and supplemental payments to ICF/ID providers. Base and supplemental payments must be separately identified. Note: any reimbursement paid outside of the MMIS should be included.
☐ Yes
☐ No
Please explain payments that are made outside of the MMIS.

Are the dates of service for the Medicaid payment data consistent with the Medicaid cost reporting period?
☐ Yes
☐ No
If no, please explain:

Where the state makes Medicaid payment outside of Attachment 4.19-D for other services furnished to ICF/ID residents, are these Medicaid payments excluded from the UPL demonstration?
☐ Yes
☐ No

Please explain any excluded Medicaid payments that are made outside of 4.19-D. Also please explain how their related costs are excluded from the computation of the cost UPL.

Medicaid payment data excludes crossover claims.
☐ Yes
☐ No

No change

No change

New Question

Does the state trend the UPL for inflation?
☐ Yes
☐ No
Explain the trending factor and its source

No change

No change

Does the state trend the UPL for volume/utilization?
☐ Yes
☐ No

Please explain all additional trends or factors that are used in the demonstration and their application:

Does the state apply a claims completion factor to the Medicaid day and/or charge data?
☐ Yes
☐ No
Please explain the claims completion factor and its application:

Does the state apply a claims completion factor to the payment data?
☐ Yes
☐ No
Please explain the claims completion factor and its application:

Is the claims completion factor equally applied to the payment and Medicaid day and/or charge data?
☐ Yes
☐ No

New Question

New Question

New Question

New Question

Charge Ratio Methodology (applies to both state-developed cost report and Medicare-based cost report)

Charge Ratio Methodology (applies to both state-developed cost report and Medicare-based cost report)
Does the cost report calculate cost-to-charge ratios for defined cost centers to which allowable costs are allocated?
☐ Yes
☐ No

Does the cost report capture all payer cost-to-charge ratios?
☐ Yes
☐ No

Are the cost-to-charge ratios applied on a facility-wide or cost center-specific basis?
☐ Facility-wide, inclusive of both routine and ancillary cost centers
☐ Facility-wide, but only for ancillary cost centers (routine cost center is on a per diem basis)
☐ Cost center-specific, for each ancillary cost center only (routine cost center is on a per diem basis)
☐ Cost center-specific, for each ancillary and routine cost center

Does the state apply the Medicaid ICF/ID charges to the cost-to-charge ratios from the same time period as the cost report data?

☐ Yes
☐ No

Are the Medicaid billed and covered charges reported to the MMIS?

☐ Yes
☐ No

Please specify the time period of the data used in the state's cost report.

_____

Does the dollar amount of payments for the UPL base period equal the "claimed" amounts on the CMS-64, Medicaid Expenditures report for the UPL time period?

☐ Yes
☐ No
If no, please provide a reconciliation and explanation of the difference?

Explain the volume/utilization adjustment, including: how it will assure the UPL does not over or understate the volume of Medicaid ICF/ID services provided in the rate year, how it is applied and that it is applied consistently to the Medicare equivalent (the UPL) and Medicaid payment data:

VI. The state meets ICF/ID UPL demonstration requirements, as below:
The state has submitted supporting spreadsheet data to CMS, by provider, that demonstrates:
The state under the UPL in the aggregate for state-owned ICF/IDs?

☐ Yes
☐ No

The state under the UPL in the aggregate for non-state-owned ICF/IDs?

☐ Yes
☐ No

The state under the UPL in the aggregate for private ICF/IDs?

☐ Yes
☐ No

Explanation	Burden Change
CMS folded the Old Guidance & Instructions documents into 1 online form that asks questions that before were open text boxes that states had to fill in to explain their methodology. Here the crosswalk includes any changes. For ICF IIDs, the open questions about the UPL methdology was not in the guidance. We have added these to keep each UPL submission uniform in terms of data and justification.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
	No
	No
	No
	No
	No
	No
	No
Updated federal cost principle references	No

No
No
No

No

No
No
No

No

No

No

No

No

No
No

No

No
No

No

No

No

No

No

No

No

No

No

No

No

No

No

No

	No
	No
	No
	No
These are ICF/IID specific questions that clarify the UPL submission	No
These are ICF/IID specific questions that clarify the UPL submission	No
These are ICF/IID specific questions that clarify the UPL submission	No
These are ICF/IID specific questions that clarify the UPL submission	No
This question was removed as no longer relevant given the other questions asked.	
This question was removed as no longer relevant given the other questions asked.	
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This question was removed as no longer relevant given the other questions asked.

These questions were removed as no longer relevant given the other questions asked.

No.	UPL PRTF Guidance Questions in MACFin System
Section I: UPL Demonstration Overview	
1	Are there any significant changes to the prior year UPL methodology?
2	Does the UPL demonstration align with your state fiscal year?
3	Does the UPL demonstration trend data from the previous UPL demonstration submission or does it contain new data? If using trended data, please specify which data variables are trended.
4	Does the UPL demonstration include a full 12 months of data for each provider?
5	Is the beginning date of the data more than 2 years from the beginning date of the UPL demonstration period?
6	Has the provider count (providers enrolled in the Medicaid program and included in the UPL demonstration) changed from the previous UPL demonstration?
6a	Please explain the changes, including any new providers, closed providers, or mergers. Please also cite the source of this data.
6b	Please list any changes in the provider category designations (SGO, NSGO, and Private).
7	Indicate the percentage of managed care and FFS in the state's Medicaid program overall and also for PRTF services.
Section II: Basis of the UPL Demonstration	
1	What is the basis of the UPL formula?
2	Please provide a general description of the formula.
3	What is the time period of the data?
4	Is the data the most recently available to the state?
Section III: The source of the provider's customary charge data is:	
1	Does the state use claims data from the MMIS to determine customary charges for equivalent Medicaid services?
2	Are the providers' charges uniform for all payers?
3	Describe how the data reflects or is adjusted to account for locality.

No Question

No Question

Section IV: The prevailing charge in the locality for comparable services under comparable cir

1 Was the prevailing charge data for this provider available to the state Medicaid agency?

2 Do the prevailing charge data used in the calculation come from claims data from the MMIS?

3 Describe how the data reflects or is adjusted to account for locality.

4 Describe how the data reflects or is adjusted to represent comparable services under comparable circumstances.

5 Does the demonstration use prevailing charges for the same services that are paid under the Medicaid program?

No Question

Section V: The UPL demonstration applies Medicaid payment data as follows:

1 Are Medicaid base payment data reported from the MMIS?

2 Does the Medicaid payment data include ALL base and supplemental payments to PRTF providers?

3 Do Medicaid payment data exclude crossover claims?

4 Is the Medicaid payment reported gross or net of the primary payer payments, deductibles and co-pays?

5 Describe how Medicaid payment rate changes between the base period and the UPL period are accounted for in the demonstration.

No Question

5a Are all adjustments related to approved SPAs between the Medicaid data base period and UPL demonstration period accounted for in the demonstration?

Section VI: The State trends or adjusts the UPL data, as follows:

1	Does the state trend the UPL for inflation?
1a	Is the inflation factor trend applied from mid-point to mid-point in order to most accurately project future experience?
2	Does the state trend the UPL for volume/utilization?
	No Question
3	Are there any additional trends or factors for the UPL (not for the Medicaid payments) that are used in the demonstration and their application?
4	Does the state apply a claims completion factor (when a state does not have a full year of data for the trending factors) to the charge data?
5	Does the state apply a claims completion factor to the payment data?
5a	If Yes, is the claims completion factor equally applied to the payment and Medicaid charge data used in computing the Medicare UPL (all data in the demonstration should be for a full year)?

Section VII: The state UPL data demonstration is structured as follows:

1	Did the state conduct the UPL demonstration individually for each facility?
	No Question
2	Explain any significant increases or decreases in the UPL Gap from the prior year's UPL demonstration for each applicable provider category (SGO, NSGO, and Private).
3	Does the demonstration include all PRTFs that receive payments under Medicaid?
4	Does the data demonstration only include in-state PRTFs?

Original Document (PRA completed in January 2021)

New Question
New Question

New Question
New Question

New Question

New Question

New Question

New Question

New Question

I. The basis of the UPL formula is:
 Payment at the provider's customary charge compared to Medicaid payment, and
 Payment is made at the customary charge level and limited to the prevailing charge in the locality for comparable services under comparable circumstances

Please provide a general description of the formula:

What is the time period of the data, including the beginning and ending dates?
Base year data: _____
Rate year data: _____

No change

 The state uses claims data from the MMIS to determine customary charges for equivalent Medicaid services.
Describe other source(s):

Are the providers' charges uniform for all payers?
 Yes
 No
If no, please explain how the state calculated the providers' customary charges and the source of the data that is used in the calculation:

New Question

Does the demonstration use customary charges for the same services that are paid under the Medicaid program?
0 Yes
0 No

If the services represented in the charge comparison data are different from those paid through Medicaid, please explain the differences.

cumstances:

The prevailing charge data for this provider was available to the state Medicaid agency:
 Yes
 No

The source of the prevailing charge data used in the calculation:
 Claims data from the MMIS
Describe other source(s) and the basis for determining prevailing charges:

No change

No change

No change

If the services represented in the charge comparison data are different from those paid under Medicaid, please explain the differences.

Medicaid base payment data is reported from the MMIS.
0 Yes
0 No If the source of the payment data is a different source, please explain:

Medicaid payment data includes ALL base and supplemental payments to providers. Note: any reimbursement paid outside of MMIS should also be included within the demonstration the base and supplemental payments must be separately identified.
0 Yes
0 No Please explain payments that are made outside of the MMIS.

Medicaid payment data exclude crossover claims.
0 Yes
0 No

Is the Medicaid payment reported gross or net of primary care payments, deductibles and co-pays?
0 Gross
0 Net

Describe how Medicaid payment rate changes between the base period and the UPL period are accounted for in the demonstration?

Does the dollar amount of payments for the UPL base period equal the “claimed” amounts on the CMS-64, Medicaid Expenditures report for the UPL time period?
0 Yes
0 No
If no, please provide a reconciliation and explanation of the difference?

New Question

The state trends the UPL for inflation
0 Yes
0 No
Explain the trending factor and its source and why it's an applicable inflation to the customary and/or prevailing charges. ¬¬¬¬¬¬¬¬¬¬¬¬¬¬

Is the inflation trend applied from “mid-point to the mid-point” in order to most accurately project future experience?
0 Yes
0 No

The state trends the UPL for volume/utilization.
¬¬¬¬¬¬¬0 Yes
0 No

Explain the volume/utilization adjustment, including: how will it assure the UPL does not over or understate the volume of Medicaid services provided in the facilities in the rate year, how it is applied and that it is applied consistently to the data used to compute the payment ceiling and Medicaid payment data:

Please explain all additional trends or factors that are used in the demonstration and their application:

Does the state apply a claims completion factor to the charge data?
0 Yes
0 No
Please explain the claims completion factor and its application:

No change

Is the claims completion factor equally applied to the payment and Medicaid charge data used in computing the limit?
0 Yes
0 No
Please explain the claims completion factor and its application

The state conducted the UPL demonstration individually for each facility.
0 Yes
0 No

Base and supplemental payments are separately identified in the demonstration.
0 Yes
0 No

New Question

New Question

New Question

Explanation	Burden Change
CMS folded the Old Guidance & Instructions documents into 1 online form that asks questions that before were open text boxes that states had to fill in to explain their methodology. Here the crosswalk includes any changes. For ICF IIDs, the open questions about the UPL methdology was not in the guidance. We have added these to keep each UPL submission uniform in terms of data and justification.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
	No
	No
	No
	No
	No
	No
Clarification for locality differences in payments	No

	No
	No
	No
	No
	No
	No
	No
This question was removed as no longer relevant given the other questions asked.	No
	No
	No
	No
	No
	No
	No
This question was removed as no longer relevant given the other questions asked.	No
	No

	No
	No
	No
This question was removed as no longer relevant given the other questions asked.	No
	No
	No
	No
	No
	No
This question was removed as no longer relevant given the other questions asked.	No
These are PRTF specific questions that clarify the UPL submission	No
These are PRTF specific questions that clarify the UPL submission	No
These are PRTF specific questions that clarify the UPL submission	No

No.	UPL Clinic Guidance Questions in MACFin System
Section I: UPL Demonstration Overview:	
1	Are there any significant changes to the prior year UPL methodology?
2	Does the UPL demonstration align with your state fiscal year?
3	Does the UPL demonstration trend data from the previous UPL demonstration submission or does it contain new data? If using trended data, please specify which data variables are trended.
4	Does the UPL demonstration include a full 12 months of data for each provider?
5	Is the beginning date of the data more than 2 years from the beginning date of the UPL demonstration period?
6	Has the provider count changed from the previous UPL demonstration?
6a	Please explain the changes, including any new providers, closed providers, or mergers. Please also cite the source of this data.
6b	Please list any changes in the provider category designations (SGO, NSGO, and Private).
7	Indicate the percentage of managed care and FFS in the state's Medicaid program overall and also for Clinic services.
	No Question
Section II: Description of Clinic services included	
1	Does this demonstration apply to all Medicaid freestanding clinics?
1a	Please describe the Medicaid freestanding clinic type(s).
State clinic service payment methodology for the services: (Sub-section)	
1	Does the state pay a Medicaid fee schedule rates for all services provided by the clinic?
2	Does the state pay clinics a fee schedule amount per CPT billing code using a percentage of the Medicare fee that is currently in effect?
3	Does the state pay clinics using an encounter rate?
3a	If yes, does the state track by CPT or other billing code the individual services that Medicaid beneficiaries actually receive?
Demonstration comprehensiveness: (Sub-section)	

1 Are all of the Medicaid clinic services provided by the providers listed above in Section II question 1a accounted for in the demonstration?

Section III: The basis of the UPL formula is:

1 What is the basis of the UPL formula?

2 What is the time period of the data used in the demonstration, including the beginning and ending dates?

3 Is the data the most recently available to the state?

Section IV: Medicare payment comparison is verified as described below:

1 What is the source of the UPL Medicare equivalent data (200-level series variables in the template)?

1a Is the Medicare fee schedule for the same time period as the Medicaid payment data?

1b What is the date of the Medicare fee schedule that is used in the demonstration?

Identification of Medicare Equivalent Codes: (Sub-section)

1 Are all Medicaid services linked to a Medicare-equivalent CPT code?

1a If the services are not directly comparable to a Medicare payment for a particular billing code, can the state demonstrate a reasonably equivalent Medicare code to compare to the Medicaid payment?

2 Does the state apply Medicaid volume of service rendered within the demonstration period to each CPT code?

3 Is the volume determined based on an analysis of claims data from the MMIS?

Section V: Medicare cost comparison is verified as described below:

1 What is the source of the UPL Medicare equivalent data (200-level series variables in the template)?

State Developed Cost Report (Sub-section)

1 Does the cost report recognize allowable and non-allowable costs in accordance with Medicare Reimbursement Principles (PRM-15-1) and 45 CFR 75?

2 Has the Centers for Medicare and Medicaid Services (CMS) reviewed the cost report?

3 Do providers submit the cost reports to the State Medicaid agency annually?

4 Is the cost report audited by the state agency or through an independent audit?

Direct Cost Finding Methodology (Sub-section)

1 Does the cost report identify costs directly for Medicaid allowable service cost using an allocation methodology?

2 Please describe the cost identification and allocation process (including the recognized direct costs, treatment of indirect cost, all allocation methods used to determine the costs related to Medicaid services).

Charge Ratio Methodology (Sub-section)

1 Does the cost report capture all payer cost-to-charge ratios?

2 Does the state apply the Medicaid clinic charges to the cost-to-charge ratios from the same time period as the cost report data?

3 Are the Medicaid charges reported to the MMIS?

4 Please specify the time period of the data used in the state's cost report.

Medicare FQHC Cost Report (Sub-section)

1 Does the provider submit FQHC-based cost reports annually to the state?

2 Has the Centers for Medicare and Medicaid Services (CMS) reviewed the cost report?

3 Does the state capture the same types of allowable costs as reported on the Medicare FQHC cost report?

4 Please explain all discrepancies and modifications to the FQHC cost report.

5 Please specify the time period of the data used in the FQHC cost report.

1 No Question

2 No Question

3 No Question

4 No Question

5 No Question

Section VI: Source of the Medicaid Payment Data

1 Are Medicaid base payment data reported from the MMIS?

2 Are the dates of service for the Medicaid payment data consistent with the Medicaid charge data and/or the clinic cost reporting period?

3 Does the Medicaid payment data include ALL base and supplemental payments to clinic providers?

4 Do Medicaid payment data exclude crossover claims?

5 Is the Medicaid payment reported gross or net of primary care payments, deductibles and co-pays?

6 Describe how Medicaid payment rate changes between the base period and the UPL period are accounted for in the demonstration.

6a Are all adjustments related to approved SPAs between the Medicaid data base period and UPL demonstration period accounted for in the demonstration?

Section VII: The state trends and adjusts the UPL Data, as below:

1 Does the state trend the UPL for inflation?

1a Is the inflation factor trend applied from mid-point to mid-point in order to most accurately project future experience?

2 Does the state trend the UPL for volume/utilization?

3 Are there any additional trends or factors for the UPL (not for the Medicaid payments) that are used in the UPL demonstration and their application?

4	Does the state apply a claims completion factor (when a state does not have a full year of data for the trending factors) to the charge data?
5	Does the state apply a claims completion factor to the payment data?
5a	If Yes, is the claims completion factor equally applied to the payment and Medicaid charge data used in computing the Medicare UPL (all data in the demonstration should be for a full year)?

Section VIII: The state meets clinic UPL demonstration requirements, as below:

1	Explain any significant increases or decreases in the UPL Gap from the prior year's UPL demonstration for each applicable provider category (SGO, NSGO, and Private).
2	Does the demonstration include all clinic facilities that receive payments under Medicaid?
3	Does the demonstration only include in-state clinics?

Original Document (PRA completed in January 2021)

New Question
New Question

New Question
New Question

New Question
New Question

New Question

New Question

New Question

I. Services are subject to the clinic UPL as described below:
☐ Covered and paid under the clinic benefit in the state plan, and
☐ Provided by freestanding clinics (i.e. excludes: provider-based entities, Federally Qualified Health Clinics, FQHC look-alikes or rural health clinics)
☐ Other (please describe below)

This demonstration description applies to:
☐ All Medicaid freestanding clinics
The Medicaid freestanding clinic type(s) described below:

State clinic service payment methodology for the services:
Does the state pay a Medicaid rate for all services provided by the clinic?
☐ Yes
☐ No

Does the state pay clinics a fee schedule amount per CPT billing code using a percentage of the Medicare fee that is currently in effect?
☐ Yes
☐ No
If yes, state the percentage: _____

Does the state pay clinics using an encounter rate?
☐ Yes
☐ No

If yes, does the state track by CPT or other billing code the individual services that Medicaid beneficiaries actually receive?
☐ Yes
☐ No
If no, please explain.

Demonstration comprehensiveness:
Are all of the Medicaid clinic services provided by the providers listed above accounted for in the demonstration?
☐ Yes
☐ No
If no, please explain

II. The basis of the UPL formula is:
☐ State payment rate schedule to Medicare RBRVS Comparison Demonstration (Medicare non-facility fee schedule per CPT)
☐ Medicaid Cost Demonstration
☐ Other (please describe below):

What is the time period of the data, including the beginning and ending dates?
Base year data: _____
Rate year data: _____

Is the data the most recently available to the state?
☐ Yes
☐ No

The source of the UPL Medicare equivalent data is:
☐ Medicare Fee Schedule

No change

No change

Identification of Medicare Equivalent Codes:
Are all Medicaid services linked to a Medicare-equivalent CPT code?
☐ Yes
☐ No
If no, please explain and provide a crosswalk between CPT and local codes

If the services are not directly comparable to a Medicare payment for a particular billing code, can the state demonstrate reasonably equivalent Medicare code to compare to the Medicaid payment?
☐ Yes
☐ No
If yes, please explain the Medicare codes, or equivalent codes, used in the demonstration and the equivalent Medicai payment.

No change

Is the volume determined based on an analysis of claims data from the MMIS?
☐ Yes
☐ No
Please describe the analysis:

The source of the UPL Medicare equivalent data is:
☐ State Developed Cost Report using Medicare Cost Identification Principles
☐ Modified Medicare Federally Qualified Health Center (FQHC) Cost Report Template (CMS 222)

State developed cost report:
Does the cost report recognize allowable and non-allowable costs in accordance with Medicare Reimbursement Principles (PRM-15-1) and OMB Circular A-87?
☐ Yes
☐ No

No change

No change

Is the cost report audited by the state agency or through an independent audit?
☐ Yes
☐ No
If yes, what is the frequency of the audit?

No change

Please describe the cost identification and allocation process (including the recognized direct costs, treatment of indirect cost, all allocation methods used to determine the costs related to Medicaid services). You may also satisfy this informatio request by attaching your cost report and cost report instruction.

No change

No change

No change

No change

Does the provider submit FQHC-based cost reports annually to the state?
☐ Yes
☐ No
If no, what is the reporting period?

No change

Does the state capture the same types of allowable costs as reported on the Medicare FQHC cost report?
☐ Yes
☐ No
If no, has the state documented and explained the cost category discrepancies?

No change

No change

V. The state UPL data demonstration is structured as follows:
The state conducted the UPL demonstration separately for government owned or operated, non-state government owned or operated and privately owned or operated clinics.
☐ Yes
☐ No

All Medicaid base and supplemental payments are included in the demonstration and are separately identified.
☐ Yes
☐ No

The demonstration includes all clinic facilities that receive payments under Medicaid.
☐ Yes
☐ No

The demonstration only includes in-state clinics.
☐ Yes
☐ No

If the state includes out-of-state clinics in the UPL calculation, please verify that the data on cost/payments was obtained from the cost report of the out-of-state clinics and that the clinics are included in the "private" provider category?
☐ Yes
☐ No

Medicaid base payment data is reported from the MMIS.
☐ Yes
☐ No
If the source of the payment data is a different source, please explain:

Are the dates of service for the Medicaid payment data consistent with the Medicaid charge data and/or the hospital cost reporting period?
☐ Yes
☐ No
If no, please explain:

Medicaid payment data includes ALL base and supplemental payments to clinic providers. Base and supplemental payments must be separately identified. Note: any reimbursement paid outside of the MMIS should be included.
☐ Yes
☐ No
Please explain payments that are made outside of the MMIS.

No change

No change

No change

Does the dollar amount of payments for the UPL base period equal the "claimed" amounts on the CMS-64, Medicaid Expenditures report for the UPL time period?
☐ Yes
☐ No
If no, please provide a reconciliation and explanation of the difference?

Does the state trend the UPL for inflation?
☐ Yes
☐ No
Explain the trending factor and its source.

No change

No change

Explain the volume/utilization adjustment, including: how it will assure the UPL does not over or understate the volume o Medicaid inpatient clinic services provided in the rate year, how it is applied and that it is applied consistently to the Medicare equivalent and Medicaid payment data:
Please explain all additional trends or factors that are used in the demonstration and their application:

Does the state apply a claims completion factor to the payment data?
☐ Yes
☐ No
Please explain the claims completion factor and its application:

Does the state apply a claims completion factor to the charge data?
☐ Yes
☐ No
Please explain the claims completion factor and its application:

Is the claims completion factor equally applied to the payment and charge data?
☐ Yes
☐ No

New Question

The state has submitted supporting spreadsheet data to CMS, by provider, that demonstrates:
The state under the UPL in the aggregate for state-owned clinics.
☐ Yes
☐ No
The state under the UPL in the aggregate for non-state-owned clinics.
☐ Yes
☐ No
The state under the UPL in the aggregate for private clinics.
☐ Yes
☐ No

New Question

Explanation	Burden Change
CMS folded the Old Guidance & Instructions documents into 1 online form that asks questions that before were open text boxes that states had to fill in to explain their methodology. Here the crosswalk includes any changes. For ICF IIDs, the open questions about the UPL methdology was not in the guidance. We have added these to keep each UPL submission uniform in terms of data and justification.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
	No
	No
This question was removed as no longer relevant given the other questions asked.	No
	No
	No
	No
	No
	No
	No

No

No

No

No

No

No

No

No

No

No

No

No

Updated federal cost principles regulation citation.	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No

This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No
	No
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	No
	No
	No
	No
	No

	No
	No
	No
Added for data consistency from year to year	No
Consolidation of 3 questions into 1	No
Added for data consistency in clinics included in UPL	No

No.	UPL Physician Guidance Questions in MACFin System
	No question
	No question
	No question
	No question
	No question
	No question
	No question
	No question

Section I: UPL Demonstration Overview:

1	Are there any significant changes to the prior UPL methodology?
2	Does the UPL demonstration align with your state fiscal year?
3	Does the UPL demonstration include a full 12 months of data for each provider?

4	Is the beginning date of the data more than 2 years from the beginning date of the UPL demonstration period?
5	Has the provider count changed from the previous UPL demonstration?
5a	Please explain the changes, including any new providers, closed providers, or mergers. Please also cite the source of this data.

Section II: Type of Demonstration and Payment Methodology

1	Which type of demonstration is used to demonstrate the enhanced payments?
2	Indicate the payment methodology for the enhanced payments (Average Commercial Rate)
3	Indicate the payment methodology for the enhanced payments (Medicare Equivalent of the Average Commercial Rate)

Section III. Data Requirements

Information about Payers (Sub-section)

1	Select from the following options: The ACR or Medicare Equivalent of the ACR demonstration includes the top (generally five) commercial payers. The ACR or Medicare Equivalent of the ACR demonstration includes all commercial payers.
2	Are the third-party payer data derived from the billing systems of the providers eligible for the enhanced payment?

Payment Data (Sub-section)

1	Do the payments include all copayments and deductibles? The amount of allowed payment by the third party payers includes payment and any patient liability that together equal the total payment for a service allowed by a commercial payer.
2	When an enhanced payment is made, is the payment data included for each CPT code provided by the groups of eligible practitioners?

Authorized Codes, Dates of Service, and MMIS Data (Sub-Section)

Please confirm that the supplemental payment is made only for codes for which base payments are made and that the ACR demonstration includes only those same codes.

1 Codes that do not receive base payments cannot be included in the ACR demonstration and therefore cannot receive supplemental or enhanced payment.

2 What are the dates of service of the commercial data used in the demonstration?

3 What are the dates of the Medicaid payment and volume data used in the demonstration?

Do the dates of service in the commercial payment data match the dates of service for the Medicaid payment/volume data from MMIS?

4 For supplemental/enhanced payments made for time periods that are after the date of the ACR calculation, states must use commercial payment data that is no more than two years old to calculate the ACR.

5 Is primary commercial payment source information, such as a payment invoice, provided for at least one billing code, showing how the ACR was calculated?

6 Are the Medicaid payment and volume data derived from the MMIS?

Payers not Subject to Market Forces and Managed Care (Sub-section)

1 Are FQHCs, RHCs, Medicare, Workers Compensation, and other payers' data that are not subject to market forces excluded from the demonstration?

2 Are managed care payments made on a capitation or sub-capitation basis excluded?

3 Are managed care entity fee for service payments included?

Dually Eligible Beneficiaries (Sub-section)

1 Do the enhanced payments and data exclude services provided to beneficiaries who are dually eligible for Medicaid and Medicare?

2 Describe how payments and charges for which Medicaid is the primary payer are identified.

Eligible Providers and Practitioners (Sub-section)

1 List all providers eligible for enhanced payment by campus, geographic location, or some other criteria. This list will identify all academic medical centers, hospitals, and/or other providers that will participate in the enhanced payment.

2 Does the demonstration include separate provider-specific ACR calculations or does it calculate only one ACR that includes all providers of these provider-specific payments?

3 Are enhanced payments made to non-physicians practitioners?

4 Are data included in the demonstration for all of the types of practitioners whose services are eligible for the enhanced/supplemental payment?

5 Are supplemental payments made for providers working under the supervision of a physician?

6 Are supplemental payments made for non-physician practitioners?

7	Are non-professional services excluded from the data?
8	Please describe how the services of all providers that are eligible for the enhanced/supplemental payment were identified.

Radiology, Clinical Diagnostic Laboratories, and Anesthesia Services (Sub-section)

1	Does the demonstration exclude the technical component of radiology services?
2	Are any clinical diagnostic laboratory (CDL) services included in the demonstration?
2a	Are payments for these services made at or below the Medicare rate on a per test basis, as required by section 1903(i)(7) of the Social Security Act?
2b	Please list any CDL codes that have been included in the demonstration.
3	Please explain if the Medicaid payment for anesthesia services directly crosswalks to Medicare payment. In the explanation also indicate if the Medicaid payments are made using the same units of service for time increments as Medicare. If Medicaid does not directly crosswalk to Medicare, please explain how the methodology addresses any differences between the Medicare and Medicaid services.

Section IV: Steps in Calculating Payment Ceiling using the ACR

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 should 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 should submit a copy of the invoice which accompanies payment from one 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 as well as the spreadsheet detailing the commercial payments can be masked to hide the identity of the payers. States must, however, disclose the names of the commercial payers included in the calculation of the ACR.

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 the Average Commercial Rate

Calculate the average commercial rate per procedure code from the allowed payment amount from each eligible provider's billing system for the top (generally five), or for all, commercial third party payers (TPP) for the base period. Please see the narrative for further explanation and instructions in calculating the ACR per procedure.

1 Please indicate the name of the spreadsheet submitted to document the detailed calculation of the ACR.

Step 2: Calculate the 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.

b. Add the product for all procedure codes. This total represents the supplemental/enhanced payment ceiling. Note, if enhanced payment is made on a per code basis, the payment ceiling will be a per code ceiling that equals the product of the ACR and the Medicaid volume for that code.

1 Has a payment ceiling been calculated for all practitioners eligible for enhanced/supplemental payment?

2 How is the supplemental/enhanced payment made?

3 Were practitioner supplemental/enhanced payments the net of MMIS payments for the eligible codes paid to eligible practitioners?

4 Please indicate the date of the last ACR payment ceiling calculation.

Section V: Medicare Equivalent of the Average Commercial Rate Demonstrations

States may make supplemental/enhanced 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.
The steps below describe the methodology that states can use to calculate the Medicare equivalent of the ACR to establish an upper payment ceiling for practitioner supplemental payments.

Step 1: Calculate the Average Commercial Rate

Calculate the average commercial rate per procedure code from the allowed payment amount from each eligible provider's billing system for the top (generally five), or for all, commercial third party payers (TPPs) for the base period. Please see Step 1 of the narrative section for ACR demonstrations for further explanation and instructions in calculating the ACR per procedure.

1 Please indicate the name of the spreadsheet(s) submitted to document the detailed calculation of the ACR for the procedure codes, by eligible provider, for which supplemental payment will be made.

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.

Multiply the average commercial rate as determined in Step 1 by the number of claims recorded in MMIS for the same time period as the ACR, per eligible practitioner for each procedure code that was rendered to Medicaid beneficiaries. Sum the product of all procedure codes by provider to calculate the aggregate Medicaid payment ceiling.

1 Has the Medicaid payment ceiling been calculated for each procedure code for which enhanced payment is to be made for eligible Medicaid practitioners?

2 Has the total aggregate Medicaid payment ceiling been calculated for each eligible Medicaid practitioner?

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 single statistic expresses the ACR as a percentage of Medicare and will be used to calculate enhanced Medicare payment rates for determining supplemental payments (Step 4).

The Medicare fee schedule used for the calculation of the Medicare equivalent of the ACR single statistic must be specified in the state plan. In addition, only Medicare fees for procedures that are authorized by the Medicaid state plan can be included in the calculations.

1 Are all Medicaid services matched to Medicare services by CPT/billing code?

2 Please confirm that the Medicare Physician Fee Schedule is from the same time period as the rates obtained from the commercial payers, the Medicaid rates and the Medicaid services provided.

3 Please indicate the RVUs issued by Medicare as of:

4	Do RVUs vary by site of service?
5	Are facility RVUs used?
6	Are non-facility RVUs used?
7	Do the RVUs vary by geographic locale as defined by Medicare?
8	Does the state update its methodology within a single rate year?

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 can be made on a per code basis, which would be equal to the single statistic multiplied by the Medicare rate per code. If this payment methodology is used, all base Medicaid payments must be subtracted for each procedure code to determine the maximum supplemental payment amount that can be made for that code.

1	Is the Medicare equivalent of the ACR multiplied by the Medicare rate for all eligible codes for procedures reported in MMIS?
2	Is the volume of eligible procedure codes reported from MMIS claims per eligible practitioner?
3	Is the maximum supplemental payment per eligible practitioner equal to, or less than, the Medicaid payment ceiling per practitioner, respectively?
4	Have paid claims from MMIS for the same time period as the volume reported for each eligible practitioner been subtracted from the sum of the enhanced payment rate multiplied by volume per provider?

5 How are supplemental/enhanced payments made?

6 Is the total net supplemental payment (enhanced payment less Medicaid payment) reported per eligible practitioner?

7 Are supplemental payments at or below the maximum net supplemental payments as calculated per eligible practitioner?

Original Document (PRA completed in January 2021)

I. Payment up to 100 percent of the Medicare Physician Fee Schedule.

The state should check off the following boxes, as appropriate, to indicate the Medicare Physician Fee Schedule (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 fee schedule:
Pays ___% of the MPFS

Uses RVUs issued by Medicare as of: _____ (note date here)

RVUs vary by site of service:
☐Y
☐N

Facility RVUs used
☐Y
☐N

Non facility RVUs used
☐Y
☐N

RVUs vary by geographic locale as defined by Medicare
☐Y
☐N

The state updates its methodology within a single rate year
☐Y
☐N

Explain below how the state updates its fee schedule, either within the year, or multiple years including how often these updates are made within the specified timeframe. (Please note that any change to the methodology requires submission of a SPA.)

New Question

New Question

New Question

New Question

New Question

New Question

II. Which type of demonstration and payment methodology is the state using?
 Average commercial rate (ACR) demonstration
 Medicare equivalent of the ACR demonstration

Please describe in the text box below the percentage of the Medicare equivalent of the ACR that is paid (up to 100%)

Please describe in the text box below the percentage of the Medicare equivalent of the ACR that is paid (up to 100%) Other (please specify):

 Supplemental payments to the base Medicaid rates are used

Please describe in the text box below the Medicaid base payment methodology

 An alternate fee schedule is used for enhanced payments

Please describe in the text box if payment made through an alternative fee schedule is made up to a percentage of the amount calculated through the ACR or Medicare equivalent of the ACR; please also specify the percentage paid.

Information about Payers
 The ACR demonstration includes the top (generally five) commercial payers.
 The ACR demonstration includes all commercial payers.

 The third party payer data is derived from the billing systems of the providers eligible for the enhanced payment.

States must be able to clearly demonstrate how the allowed payment amount was determined under each of the accounts receivable systems of the eligible providers

Payments include all copayments and deductibles.
☐Y
☐N
If not, please explain:

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

Payment data is included for each CPT code provided by the groups of practitioners included to which enhanced payment is made.
☐Y
☐N

- Please confirm that the supplemental payment is made only for codes for which base payments are made and that the ACR demonstration includes only those same codes. Codes that do not receive base payments cannot be included in the ACR demonstration and therefore cannot receive supplemental or enhanced payment.

For supplemental/enhanced payments that are made for concurrent ACR demonstration time periods, dates of service in the commercial payment data must match the dates of service included in the Medicaid payment/volume from MMIS.

What are the dates of service of the commercial data used in the demonstration?

- Dates of service:_____

What are the dates of the Medicaid payment and volume data used in the demonstration?

- Dates of service:

The dates of service in the commercial payment data match the dates of service included in the Medicaid payment/volume from MMIS.

For supplemental/enhanced payments made for time periods that are after the date of the ACR calculation, states must use commercial payment data that is no more than two years old to calculate the ACR.

Primary commercial payment source information, such as a payment invoice, is provided for at least one billing code showing how the ACR was calculated.

☐Y
☐N

Please list the billing code or codes provided:

- Medicaid payment and volume data are derived from MMIS.
- Medicaid payment and volume data are derived from a different source than the state's MMIS.

Using 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.

FQHCs, RHCs, Medicare, Workers Compensation, and other payers' data that are not subject to market forces are excluded from the demonstration.

☐Y
☐N

Managed care payments made on a capitation or sub-capitation basis are excluded.

☐Y
☐N

Managed care entity fee for service payments are included.

☐Y
☐N If included, please explain which services are paid on a fee for service basis, which managed care entities' data are included, and identify the state plan authority and location for these payments.

Please indicate if the enhanced payments and data exclude services provided to beneficiaries who are dually eligible for Medicaid and Medicare.
☐Y
☐N If the enhanced payment includes payments and data for dually eligible beneficiaries, please Document the authority provided in Supplement 1 to Attachment 4.19-B in the following text box:

Supplement 1 to Attachment 4.19-B of the state plan describes the payment methodology for Medicare Part A and Part B deductibles and co-insurance, as well as any instances of payment for services that are not covered by Medicare. If authorized by the state plan, in these limited circumstances Medicaid may become the primary payer of services and in these cases these data may be included in the calculation of the enhanced payments. If the state plan does not authorize payment for services not covered by Medicare, these data must be excluded from the calculation of enhanced payment.

Describe how payments and charges for which Medicaid is the primary are identified:

Identify all academic medical centers and/or hospitals that will participate in the enhanced payment. List all providers eligible for enhanced payment by campus, geographic location or some other criteria, as applicable in the text box below.

Does the demonstration include separate calculations for these provider-specific payments?
☐Y
☐N
If the state is 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.

If enhanced payments are made to non-physicians practitioners, please list all eligible provider types in the text box below.

Are data included in the demonstration for all of the types of practitioners whose services are eligible for the enhanced/supplemental payment?
☐Y
☐N
Under 42 CFR 440.50(a) physician services are defined as services furnished by a physician (1) within the scope of practice or medicine or osteopathy as defined by State law; and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. Therefore, the services by providers working under the supervision of a physician, such as nurse practitioners and physicians' assistants may be paid at the enhanced rate or supplemental ACR payment.

Are supplemental payments made for providers working under the supervision of a physician?
☐Y
☐N Please also note that the services of non-physician practitioners, which may include practitioners who are enrolled, qualified Medicaid providers can be targeted for increased payment, subject to an ACR demonstration.

Are supplemental payments made for non-physician practitioners?
☐Y
☐N

Are non-professional services are excluded from the data?
☐Y
☐N

In the text box provided below, please describe how the services of all providers that are eligible for the supplemental/enhanced payment were identified

Does the demonstration exclude the technical component of radiology services?
☐Y
☐N 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 radiology films. Only the professional component of radiology services should be included in the demonstration if an enhanced payment is made for radiology services.

Are any clinical diagnostic laboratory (CDL) services included in the demonstration?
☐Y
☐N

Are payments for these services made at or below the Medicare rate on a per test basis, as required by section 1903(i)(7) of the Social Security Act?
☐Y
☐N 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.

No change

No change

No change

No change

No change

No change

A payment ceiling has been calculated for all practitioners eligible for enhanced/supplemental payment.
☐Y
☐N

☐Supplemental/enhanced payment is made on a per code payment ceiling basis.

☐Supplemental/enhanced payment is made based on the aggregate payment ceiling (the sum of all per code payment ceilings).

Please note that any supplemental or enhanced payment can only be made up to a maximum of the payment ceiling less Medicaid payment in total from MMIS.

Please indicate if practitioner enhanced/supplemental payments were net of MMIS payments for the eligible codes paid to eligible practitioners.
☐Y
☐N

Please indicate in the text box below, the date of the last ACR payment ceiling calculation. Please note that if the ACR is used to determine practitioner supplemental payment, the ACR payment ceiling must be calculated annually.

No change

No change

No change

The Medicaid payment ceiling has been calculated for each procedure code for which enhanced payment is to be made for eligible Medicaid practitioners.
☐Y
☐N

The total aggregate Medicaid payment ceiling has been calculated for each eligible Medicaid practitioner.
☐Y
☐N

No change

All Medicaid services are matched to Medicare services by CPT/billing code.
☐Y
☐N

 Please verify that that correct Medicare fee schedule, as specified in the State plan, has been used to compare Medicaid and Medicare services.

Please indicate the RVUs issued by Medicare as of: (note date here)_____

RVUs vary by site of service
☐Y
☐N

Facility RVUs used
☐Y
☐N

Non facility RVUs used
☐Y
☐N

Varies by geographic locale as defined by Medicare
☐Y
☐N

The state updates its methodology within a single rate year
☐Y
☐N

No change

The Medicare equivalent of the ACR is multiplied by the Medicare rate for all eligible codes for procedures reported in MMIS.
☐Y
☐N

The volume of eligible procedure codes is reported from MMIS claims per eligible practitioner.
☐Y
☐N

The maximum supplemental payment per eligible practitioner is equal to, or less than, the Medicaid payment ceiling per practitioner, respectively.
☐Y
☐N

Paid claims from MMIS for the same time period as the volume reported for each eligible practitioner has been subtracted the sum of the enhanced payment rate multiplied by volume per provider.
☐Y
☐N

- Enhanced payments are made per code, rather than as an aggregate amount equal to the sum of the enhanced payment per code.
- Supplemental payment is made based on the aggregate amount, or sum, of all eligible procedure codes.

The total net supplemental payment (enhanced payment less Medicaid payment) is reported per eligible practitioner.
☒Y
☐N

Please note that any supplemental or enhanced payment can only be made up to a maximum of the payment ceiling less Medicaid payment in total from MMIS (net supplemental payments).

Supplemental payments are at or below the maximum net supplemental payments as calculated per eligible practitioner.
☐Y
☐N

Explanation	Burden Change
This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No
This question was removed as no longer relevant given the other questions asked.	No
CMS folded the Old Guidance & Instructions documents into 1 online form that asks questions that before were open text boxes that states had to fill in to explain their methodology. Here the crosswalk includes any changes. For ICF IIDs, the open questions about the UPL methdology was not in the guidance. We have added these to keep each UPL submission uniform in terms of data and justification.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No

This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
This question added to the UPL submission for uniformity of data.	No
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No

No

Area	Medicaid Standard Funding Questions
Title	**Medicaid Funding Questions**
Overview of Questions	The following questions should be answered in relation to all payments made to all providers reimbursed pursuant to a methdology for each of the applicable services that are submitted pursuant to SMDL #13-003.

Original Document (PRA completed in January 2021)	Explanation	Burden Change
Funding Questions	clarifies these are for Medicaid	0
The following questions are being asked and should be answered in relation to all amended payments made to providers paid pursuant to a methodology described in Attachments 4.19-A, 4.19-B, and 4.-19-D of this SPA.	clarifies these standard questions are asked for each of the state plan pages listed.	0