No.	UPL Guidance Question	Response or Follow-Up Questions
Section I: UPL Demonstration Overview:		
1	Are there any significant changes to the prior UPL methodology?	Insert the following options: Yes No If 'Yes' is selected, insert the following question: If Yes, please explain. Insert Text Box
2	Does the UPL demonstration align with your state fiscal year?	Insert the following options: Yes No If 'No' is selected, insert the following question: If No, please explain. Insert Text box Add the following note: Note: The UPL demonstration period should start the day after the previous UPL demonstration period's end date.
3	Does the UPL demonstration include a full 12 months of data for each provider?	Insert the following options: Yes No If 'No' is selected, insert the following question: If No, please explain. Insert Text Box
4	Is the beginning date of the data more than 2 years from the beginning date of the UPL demonstration period?	Insert the following options: Yes No If 'Yes' is selected, insert the following question: If Yes, please explain. Insert Text box
5	Has the provider count changed from the previous UPL demonstration?	Insert the following options: Yes No If 'Yes' is selected, proceed to question 5a.
5a	Please explain the changes, including any new providers, closed providers, or mergers. Please also cite the source of this data.	Insert Text Box
Section II: Type of Demonstration and Payment Methodology		
1	Which type of demonstration is used to demonstrate the enhanced payments?	Average Commercial Rate Medicare Equivalent of the Average Commercial Rate If more than one demonstration type is selected, explain which providers receive each kind of payment. (Note: If only one demonstration type is selected then enter "not applicable"). Insert Text Box If user selects ACR then display question 2 If user selects Medicare Equivalent of the ACR then display question 3
2	Indicate the payment methodology for the enhanced payments (Average Commercial Rate)	Alternative Fee Schedule Supplemental payments to the base rates If the user selects Alternate Fee Schedule then display the following question: 2a. Indicate the percentage of the Average Commercial Rate (ACR) that is paid (up to 100%) using the Alternative Fee Schedule Insert Text box If the user selects Supplemental payments to the baser rates then display the following questions: 2b. Indicate the percentage of the Average Commercial Rate (ACR) that is paid (up to 100%) using Supplemental Payments to the base rates Insert Text Box 2c. Describe the base payment methodology for which the supplemental payments are attributed Insert Text box
3	Indicate the payment methodology for the enhanced payments (Medicare Equivalent of the Average Commercial Rate)	Alternative Fee Schedule Supplemental payments to the base rates If the user selects Alternate Fee Schedule then display the following question: 3a. Indicate the Medicare Equivalent of the Average Commercial Rate percentage that is paid using the Alternative Fee Schedule. Insert Text box If the user selects Supplemental payments to the baser rates then display the following questions: 3b. Indicate the Medicare Equivalent of the Average Commercial Rate percentage that is paid using Supplemental Payments to the base rates. Insert Text Box 3c. Describe the base payment methodology for which the supplemental payments are attributed. Insert Text box
Section III. Data Requirements		
Information about Payers (Sub-section)		
1	Select from the following options:	Insert 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?	Insert the following options: Yes No
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. Note: 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.	Insert the following options: Yes No If No is selected, insert the following question: If No, please explain. Insert Text Box
2	When an enhanced payment is made, is the payment data included for each CPT code provided by the groups of eligible practitioners?	Insert the following options: Yes No If No is selected, insert the following question: If No, please explain. Insert Text Box
Authorized Codes, Dates of Service, and MMIS Data (Sub-Section)		
1	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.	Insert confirmation/verification check box
2	What are the dates of service of the commercial data used in the demonstration?	Dates of Service: Insert Text Box
3	What are the dates of the Medicaid payment and volume data used in the demonstration?	Dates of Service: Insert Text Box

	4	Do the dates of service in the commercial payment data match the dates of service for the Medicaid payment/volume data 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. Note: 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.	Insert the following options: Yes No If No is selected, insert the following question: If No, please explain. Insert Text Box
	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?	Insert the following options: Yes No If Yes is selected, insert the following question: If Yes, please list the billing code or codes provided. Insert Text Box
	6	Are the Medicaid payment and volume data derived from the MMIS? Note: 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.	Insert the following options: Yes No If No is selected, insert the following question: If No, please describe the different source from which Medicaid payment and volume data are derived. Insert Text Box
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?	Insert the following options: Yes No
	2	Are managed care payments made on a capitation or sub-capitation basis excluded?	Insert the following options: Yes No
	3	Are managed care entity fee for service payments included?	Insert the following options: Yes No If Yes is selected, insert the following question: If Yes, 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. Insert Text Box
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?	Insert the following options: Yes No If No is selected, insert the following question: If No, please document the authority provided in Supplement 1 to Attachment 4.19-B in the following text box Note: 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. Insert Text Box
	2	Describe how payments and charges for which Medicaid is the primary payer are identified.	Insert Text Box
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.	Insert Text Box
	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? Note: 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.	Insert the following options: Separate Provider-Specific ACR Calculations One ACR Calculation that Includes All Providers
	3	Are enhanced payments made to non-physicians practitioners?	Insert the following options: Yes No If Yes is selected, insert the following question: If Yes, please list all eligible provider types. Insert Text Box
	4	Are data included in the demonstration for all of the types of practitioners whose services are eligible for the enhanced/supplemental payment? Note: In order for a provider to receive enhanced/supplemental payments, the state must provide commercial and Medicaid data for that provider.	Insert the following options: Yes No
	5	Are supplemental payments made for providers working under the supervision of a physician? Note: 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.	Insert the following options: Yes No
	6	Are supplemental payments made for non-physician practitioners? Note: 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.	Insert the following options: Yes No
	7	Are non-professional services excluded from the data?	Insert the following options: Yes No
	8	Please describe how the services of all providers that are eligible for the enhanced/supplemental payment were identified.	Insert Text Box
Radiology, Clinical Diagnostic Laboratories, and Anesthesia Services (Sub-section)			
	1	Does the demonstration exclude the technical component of radiology services? Note: 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.	Insert the following options: Yes No
	2	Are any clinical diagnostic laboratory (CDL) services included in the demonstration?	Insert the following options: Yes No If the user selects "Yes" for this question then questions 2a and 2b should be made available. If the user selects "No" then do not ask 2a and 2b.

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? Note: 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.	Insert the following options: Yes No
2b	Please list any CDL codes that have been included in the demonstration.	Insert Text Box
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. Note: 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, which is by 15-minute unit. Additionally, if the State 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.	Insert Text Box
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.	Insert Text Box
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?	Insert the following options: Yes No
2	How is the supplemental/enhanced payment made? Note: Any supplemental or enhanced payment can only be made up to a maximum of the payment ceiling less Medicaid payment in total from MMIS.	Insert the following options: The supplemental/enhanced payment is made on a per code payment ceiling basis The supplemental/enhanced payment is made on the aggregate payment ceiling (the sum of all per code payment ceilings)
3	Were practitioner supplemental/enhanced payments the net of MMIS payments for the eligible codes paid to eligible practitioners?	Insert the following options: Yes No
4	Please indicate the date of the last ACR payment ceiling calculation. Note: If the ACR is used to determine practitioner supplemental payment, the ACR payment ceiling must be calculated annually.	Insert Text Box
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.	Insert Text Box

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?	Insert the following options: Yes No
2	Has the total aggregate Medicaid payment ceiling been calculated for each eligible Medicaid practitioner?	Insert the following options: Yes No
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?	Insert the following options: Yes No
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.	Insert confirmation/verification check box
3	Please indicate the RVUs issued by Medicare as of:	Date: Insert Text Box
4	Do RVUs vary by site of service?	Insert the following options: Yes No
5	Are facility RVUs used?	Insert the following options: Yes No
6	Are non-facility RVUs used?	Insert the following options: Yes No
7	Do the RVUs vary by geographic locale as defined by Medicare?	Insert the following options: Yes No
8	Does the state update its methodology within a single rate year?	Insert the following options: Yes No
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?	Insert the following options: Yes No
2	Is the volume of eligible procedure codes reported from MMIS claims per eligible practitioner?	Insert the following options: Yes No
3	Is the maximum supplemental payment per eligible practitioner equal to, or less than, the Medicaid payment ceiling per practitioner, respectively?	Insert the following options: Yes No
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?	Insert the following options: Yes No
5	How are supplemental/enhanced payments made?	Insert the following options: Payments are made per code, rather than as an aggregate amount equal to the sum of the enhanced payment per code Payments are made based on the aggregate amount, or sum, of all eligible procedure codes
6	Is the total net supplemental payment (enhanced payment less Medicaid payment) reported per eligible practitioner?	Insert the following options: Yes No
7	Are supplemental payments at or below the maximum net supplemental payments as calculated per eligible practitioner? Note: 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) for each eligible provider.	Insert the following options: Yes No