DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

FEB 2 5 2013

Jason A. Helgerson
State Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
Empire State Plaza
Corning Tower (OCP-1211)
Albany, NY 12237

RE: TN 11-07B

Dear Commissioner Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #11-07B has been approved for adoption into the State Medicaid Plan with an effective date of April 1, 2011. The SPA authorizes supplemental payments to certain eligible providers, for eligible medical professional services provided while acting as a participant in the Roswell Park Cancer Practice Plan.

Enclosed are copies of SPA #11-07B and the CMS-179 form, as approved.

If you have any questions, please contact Peter Marra at 518-396-3810, ext. 104, or Rob Weaver at 410-786-5914.

Sincerely,

[redacted]

Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **#11-07-B**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 2011**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 04/01/11-09/30/11 $ 170,742** **b. FFY 10/01/11-09/30/12 $ 319,502**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Page 1.5, 1.6, 1.7, 1.8**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Supplemental Medicaid payment for Physicians-Public Benefit Corporations
(FMAP = 56.88% 4/1/11-6/30/11; 50% 7/1/11 forward)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY [redacted] YS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE O [redacted] AL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Operations & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: January 25, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **February 25, 2013**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **April 1, 2011**	20. SIGNATURE OF REGIONAL OFFICIAL [redacted]
21. TYPED NAME: **Michael Melendez**	22. TITLE: **Associate Regional Administrator** **Division of Medicaid and State Operations**

23. REMARKS:

FORM HCFA-179 (07-92)

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Supplemental Medicaid Payments for Eligible Professional Services
2. Roswell Park Cancer Institute: Payment up to the Average Commercial Rate

(a) Effective April 1, 2011, supplemental payments will be made to Roswell Park Cancer Institute Clinical Practice Plan providers for services eligible under this provision ("Eligible Services"). Supplemental payments for Eligible Services will be equal to the difference between the Average Commercial Rate, as defined below, and Medicaid payments otherwise made under this state plan. The supplemental payment will only be applicable to the professional component of the services provided. However, supplemental fee payments will not be available for services provided at facilities participating in the Medicare Teaching Election Amendment.

(b) Roswell Park Eligible Medical Professional Providers are :

(1) Physicians, Nurse Practitioners and Physician Assistants; who are

(2) Employed by a public benefit corporation, or a non-state operated public general hospital operated by a public benefit corporation or who are providing professional services at a public benefit corporation facility as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation for those patients eligible for Medicaid; and are

(3) Licensed by the State of New York.

Excluded providers are federally qualified health centers (FQHCs) and rural health centers (RHCs).

(c) Eligible Services include only those services provided by a Roswell Park Eligible Medical Professional Provider while acting in their capacity as a participant in a plan for the management of the clinical practice at Roswell Park.

(d) Services excluded are those utilizing procedure codes not reimbursed by Medicaid, clinical laboratory services, dual eligibles except where Medicaid becomes the primary payer, and Managed Care. Managed Care data will be included only when a separate fee for service payment has been made to an eligible provider. Non commercial payers such as Medicare are excluded. Additionally, supplemental payment will not be allowed on all inclusive payments where the base payment includes the physician cost.

(e) Supplemental payments will be made as an annual aggregate lump sum payment, based on the Medicaid data applicable to dates of service in the calendar year. Initial payments will be based on claims processed within 3 months after the calendar year for those dates of service. A final payment will be made one year following the initial payment to capture those claims for the payment year date of service processed subsequent to the initial payment. Supplemental payments will not be made prior to the delivery of services.

(f) Calculating the Average Commercial Rate (ACR) For Matched Procedures.

(1) The ACR will be calculated for Roswell based on applicable rates for the appropriate region, utilizing the top 5 commercial payers based on volume.

(2) The ACR will be calculated annually before each state fiscal year using commercial payer data from the most recently completed twelve month period by Date of Service between July and June. The initial calculation, effective beginning April 1, 2011, will be based on commercial payer data from the period of July 1, 2010, through June 30, 2011 Date of Service.

(3) For Eligible Service procedures (additionally distinguished by modifier and point of service) that are billed to Medicaid using codes that correspond to those recognized by commercial payers ("Matched Procedures"), a Procedure-Specific ACR will be calculated for each Matched Procedure by dividing the sum of total commercial payments for the Matched Procedure by the total number of the Matched Procedures paid by commercial payers. For services where physician extenders may be used the applicable percentage of the ACR will be applied.

(g) Calculating ACR for Non-Matched Procedures

(1) For Eligible Service procedures that are billed to Medicaid using codes that do not correspond to those recognized by commercial payers ("Non-Matched Procedures"), a Procedure-Specific ACR will be calculated for each Non-Matched Procedure by calculating the overall average percentage of the matched procedures commercial payments to Medicaid payments.

(2) This percentage is applied to the average Medicaid payments per unit for the non matched services to establish an ACR proxy payment per unit. The units for each non matched Medicaid service is multiplied by the ACR proxy, and then totaled to determine the payment ceiling.

(3) The difference between the total Medicaid payments for the unmatched services and the ACR proxy total is the supplemental payment for unmatched services.

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(h) Determining the Supplemental Payment Amount

(1) For each Eligible Service procedure, the Procedure-Specific Ceiling Amount is the product of the Procedure-Specific ACR and the number of times the procedure was paid by Medicaid to Eligible Medical Professional Providers The sum of all Procedure-Specific Ceiling Amounts for all Eligible Service procedures is the Supplemental Payment Ceiling.

(2) The Supplemental Payment Amount is calculated by subtracting total Medicaid payments made for Eligible Services from the Supplemental Payment Ceiling.

ACR Calculation Example

Example 1.
Calculation of Average Percentage of Commercial Payments to Medicaid Payments

CPT	Fee Code	Medicaid Volume	Medicaid Payments	ACR	ACR Medicaid Volume
99201	Facility	9	$ 98.33	$ 37.56	$ 338.02
99201	Non-Facility	29	$659.46	$ 48.16	$1,396.50
99202	Facility	67	$1,451.31	$ 72.65	$4,867.86
99202	Non-Facility	68	$2,533.87	$ 83.34	$5,667.20
99203	Facility	255	$8,491.44	$110.72	$28,234.48
99203	Non-Facility	154	$8,590.88	$123.25	$18,980.55
99204	Facility	157	$8,822.54	$179.74	$28,218.70
99204	Non-Facility	115	$9,570.55	$184.33	$21,197.88
99205	Facility	63	$4,485.55	$234.13	$14,750.23
99205	Non-Facility	38	$3,805.95	$237.02	$9,006.72
	Total Fees		**$ 48,509.88**		**$ 132,658.13**
Average percentage of Commercial Payments to Medicaid Payments					**273%**

Example 2:
Calculation of Payment Ceiling for Non Matched Codes and Total Supplemental Payment

CPT	Fee Code	Medicaid Volume	Medicaid Payments	Average Medicaid Payment	Comm. % of Medicaid	Calculated ACR Proxy	Calculated Payment Ceiling
59514	Facility	2	$1,791.02	$895.51	273%	$2,448.92	$4,897.83
59840	Facility	8	$1,840.00	$230.00	273%	$628.97	$5,031.78
27600	Facility	2	$202.40	$101.20	273%	$276.75	$553.50
92014	Non-Facility	118	$6,537.35	$55.40	273%	$151.50	$17,877.44
51728	Non-Facility	10	$1,509.94	$150.99	273%	$412.92	$4,129.18
	Totals		**$11,880.71**		**Payment Ceiling**		**$32,489.73**
					Supplemental Payment		**$20,609.02**

TN#: 11-07-B New

Supersedes TN#: NEW

Approval Date: FEB 2 5 2013

Effective Date: APR 0 1 2011

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(i) Agreed Upon Procedures Requirement for ACR and supplemental payment calculation

(1) An independent accountant must conduct an Agreed Upon Procedures engagement to evaluate the ACR and supplemental payment calculations. Each plan may choose its own independent accountant, but the actual core Agreed Upon Procedures to be conducted must be presented to the State for approval. In order to evaluate the ACR and supplemental calculation, the following minimum core procedures are to be conducted by the independent accountants:

a. Validate if the Average Commercial Rate fee schedule utilized in the calculation is appropriate for the time period of the calculation.

b. Select a random sample of at least 40 procedure codes with the highest amount of total payments to verify the mathematical accuracy of the calculation.

c. Validate that only eligible providers are present in the calculation as described under this provision.

The independent accountants will design techniques that will enable them to render an "Independent Accountant's Report on Applying Agreed-Upon Procedures" to the practice plan for the State.