VI - Qualified Medicaid Practitioner Enhanced Payment and Average Commercial Rate (ACR) Supplemental Payment Demonstration Guidance

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.)

II. Which type of demonstration and payment methodology is the state using?

☐ Average commercial rate (ACR) demonstration

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

☐ 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%)

☐ 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.

III. Average Commercial Rate Demonstration

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.

Payment Data

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

If not, please explain:

Authorized Codes, Dates of Service, and MMIS Data

- 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:_____

☐ 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.

What are the dates of the Medicaid payment and volume data used in the demonstration?
☐ Dates of service:

Payers not Subject to Market Forces and Managed Care

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.

Dually Eligible Beneficiaries

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:

Eligible Providers and Practitioners

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.

Radiology, Clinical Diagnostic Laboratories, and Anesthesia Services

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.

Please list any CDL codes that have been included in the demonstration.

Please explain in the text box below if the Medicaid payment for anesthesia services directly crosswalks to Medicare payment. Please 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.

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.

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.

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. Please indicate in the text box below the name of the spreadsheet submitted to document the detailed calculation of the ACR.

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.

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.

V. Medicare Equivalent of the Average Commercial Rate Demonstrations

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

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.

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. Please indicate in the text box below 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.

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.

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

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).

Please note that 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.

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

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.

Please note that 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.

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

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