III - Clinic Services Narrative Instructions

I. Verification of Clinic UPL Services

Prior to calculating the clinic upper payment limit (UPL), states must first verify which clinic services are subject to the clinic UPL. Services provided in facilities that should be excluded from the clinic UPL include:

- Provider-based clinics under the name, ownership, and administrative and financial control of a hospital. These clinics are not included in the clinic UPL calculations; however, they are addressed under the outpatient hospital UPL.

- Similarly, Federally Qualified Health Centers (FQHCs), FQHC look-alikes and Rural Health Clinics (RHCs) are also not included in calculating the clinic UPL. Statute specifies reimbursement requirements for FQHCs and RHCs and authorizes those providers distinctly from other clinic facilities.

- Services rendered in clinic facilities but covered under another Medicaid service category and paid using the applicable professional fee-for-service rate. For instance, physician services that are provided by an enrolled Medicaid physician and paid using the state plan physician fee schedule.

Check-boxes are provided to ensure that that state is including facilities and services that are subject to the clinic UPL described at 42 CFR 447.321.

State Clinic Service Methodology

The clinic services UPL at 42 CFR 447.321 refers to a reasonable estimate of Medicare's payment for these services. However, Medicare regulations do not specifically recognize "clinic" as a provider type. Instead, Medicare recognizes the services provided by licensed medical professionals. Therefore, one way a state may demonstrate the clinic UPL is to compare the Medicare professional fee schedule rates to the state's clinic rate. This section is intended to ensure that the state's clinic payment methodology can be appropriately compared to Medicare payment for professional services.

- States that pay each clinic service individually per code at a percentage of the Medicare payment rate in effect for the payment year need only indicate the actual percentage of Medicare that is paid. If the state's rate is at or below 100 percent of the Medicare rate, no additional information is needed to demonstrate UPL compliance. Check boxes are provided to indicate payment for individual codes at a percentage of the Medicare rate. Additionally, states should indicate the percentage of Medicare that is paid in the space provided and, if possible, whether the rate pertains to a particular site of service and geographic locale as defined by Medicare.

- A number of states pay clinic providers using an encounter/visit rate (regardless of the services provided). States that pay clinics encounter or visit rates must have detailed claims information to track the specific services rendered and the associated CPT codes to allow for the comparison to the Medicare non-facility fee schedule. States that do not track the services actually received by Medicaid beneficiaries (and the associated CPT codes) should explain alternatives that the Medicaid agency uses to know the actual services that beneficiaries receive during the encounter or visit in the text box provided.

Demonstration of Comprehensiveness

All providers and services provided to beneficiaries within the demonstration period should be accounted for in the UPL demonstration. Indicate, by checking the appropriate box, whether all Medicaid clinic services rendered to beneficiaries are accounted for in the demonstration. If not, use the text-box to explain.

II. The Basis of the UPL Formula

States generally demonstrate, and CMS has accepted as a reasonable estimate of, the UPL based on a comparison of Medicaid payments to equivalent Medicare payment or Medicaid cost using Medicare principles. For clinic services, CMS also has accepted different UPL formulas within a category of provider based on the availability of a Medicare payment system unique to a particular service. For example, a state may demonstrate the UPL for ESRD and ASC services by comparing the state's rate to the Medicare fee schedule for these services; demonstrate the UPL for other clinics by comparing the state's rate to the Medicare professional fee schedule rates; and, use Medicare equivalent cost reported on cost report as the basis for the UPL for dental clinics.

- Check boxes are provided for states to indicate if the demonstration is a cost based demonstration using state developed and CMS approved cost reports and/or a payment based demonstration in which the state compares its clinic rate to the professional fee for service rate as determined through the Resource-Based Relative Value Scale (RBRVS) system, ESRD or ASC rate. States should select the payment demonstration through the RBRVS system when comparing Medicaid payments to Medicare in either situation described below:
    - Medicaid Payment to Medicare Payment – States present a side-by-side comparison, by CPT code, of the Medicaid payment for services provided in clinics to the amount reimbursed for the codes under the Medicare "non-facility" fee schedule. This report must be presented in additional to the guidance document issued with these instructions and demonstrated in the aggregate for state government owned or operated, non-state government owned or operated and privately owned facilities.
    - Medicaid Fee Schedule as a Percentage of Medicare – States pay for services as a percentage of the Medicare non-facility fee schedule.
    - Paid Encounter or Visit Rates – Clinic providers track specific services rendered and the associated CPT codes for the comparison to the Medicare non-facility fee schedule.

  - o Non-Equivalent services – State pays for services not covered under Medicare and chooses, for comparison purposes, a Medicare CPT code that is reasonably similar to the Medicaid service code, provider type and place of service.

- States that limit providers to actual incurred Medicaid cost and demonstrate the UPL using state developed and CMS approved cost reports should select the cost demonstration and detail the cost finding methodology in the narrative. Note that the state must show that the Medicaid payment is equal to or less than the Medicaid reported cost that is developed using Medicare cost reporting principles.
- States that choose to deviate from those accepted methodologies should detail the alternative methodology in the "other" text box. Any alternative methodology must present a reasonable estimate of Medicare payment and must be accepted by CMS.

III. State Medicare Payment Comparison

Source of the UPL Medicare Equivalent Data

This subsection describes the source of the data used to estimate a Medicare payment amount for equivalent Medicaid services. We are using the term "Medicare equivalent" to broadly describe the various methods that states will use to determine the UPL, since the regulations describe the amount that Medicare would pay for equivalent Medicaid services.

States may use the Medicare fee schedule, the Medicare FQHC cost report template (CMS 222) – with appropriate modifications, or a CMS approved state developed cost report that is based on Medicare cost reporting principles as the source of the Medicare data. In this section, please indicate that the Medicare fee schedule was used as the basis for the state's demonstration. If cost is used for the demonstration, skip to section VI and select the specific cost report used in the UPL. If a state uses other data sources for the UPL calculation, the "other" text box should describe the data source and application. The state should explain how the other data sources link or cross-walk to Medicare payment or cost reporting principles.

Identification of Medicare Equivalent Codes

When demonstrating the clinic UPL by comparing Medicaid payment to Medicare payment, CMS requires that states present a side-by-side comparison, by CPT code, of the Medicaid payment for services provided in clinics to the amount reimbursed for the codes under the Medicare "non-facility" fee schedule – the rates paid outside of hospital settings. This section identifies that the state is using Medicare payment data from the same time period as the Medicaid payment data and that the data is comparable by CPT code. If all services are not linked to a Medicare covered/paid CPT code, explain in the text box provided. This may occur if Medicaid pays for services that are not recognized under the Medicare program. States that pay for services that are not covered under Medicare may choose, for comparison purposes, to apply a Medicare CPT or other code that is reasonably similar to the Medicaid service code, provider type and place of service. With respect to professional services, the state may impute a Medicare-like rate by multiplying the published RVUs by the Medicare-established conversion factor. Please explain if an equivalent Medicare code cannot be demonstrated.

Once the state identifies comparable codes between Medicare and Medicaid, the Medicaid volume of service from the demonstration period must be applied to the data to calculate a reasonable Medicare estimate of Medicaid services that were provided within the demonstration period.

IV. Medicare Cost Comparison

Source of the UPL Medicare Equivalent Data

As previously mentioned, states may use the Medicare FQHC cost report template (CMS 222) – with appropriate modifications, or state developed cost report as the source of a Medicare-equivalent cost demonstration. Use the check boxes to indicate which cost report was used in the state's UPL demonstration.

When completing a cost based UPL demonstration, states must develop a cost report for clinic service providers based on Medicare Reimbursement Principles found in PRM-15-1 and OMB Circular A-87 in order to recognize allowable Medicaid service cost.

State Developed and Medicare FQHC Cost Reports

- Unlike other facility types, there are no standardized national Medicare cost reports for clinics. To calculate a reasonable Medicare estimate using a Medicaid cost report or a modified version of the FQHC cost report template, the state must develop a cost identification process for clinic service providers that follow the Medicare Reimbursement Principles found in PRM-15-1 and OMB Circular A-87 in recognizing allowable and non-allowable costs. A check-box is included to indicate that the costs are identified in accordance with the PRM-15-1 and OMBC Circular A-87.
- Use the check boxes provided to indicate that the providers' cost reports are submitted annually to the state and that CMS has performed a review of the reports.
- State cost reports are typically structured to identify all-payer cost-to-charge ratios or directly find Medicaid service costs by allocating all costs associated with Medicaid covered services to Medicaid through appropriate cost finding and allocation methods. Detailed information is requested for either cost report structure that is used to calculate the UPL.
- For states that use charge ratios, Medicaid charge data should be from the same dates of services as the cost reporting period used to derive the cost-to-charge ratios. This is important to ensure that the UPL is a reasonable estimate of Medicare payment since the clinic charges will be uniform for all payers for the reporting period. If the dates of services do not match, states should provide an explanation of the discrepancy.
- For states that use a modified version of Medicaid FQHC cost report (CMS-222) as the basis for UPL data, a state must demonstrate that the cost report captures at least the same type of information and follows the same cost determination process as the CMS 222 and its instructions. The general rule is a cost must be related to patient care and must be allowable and reasonable. Indicate if the state captures the same type of allowable costs as reported on the CMS 222 by checking the appropriate box.

- If the state does not capture uniform information, please use the text box to explain all discrepancies.

V. State UPL Data Demonstration Structure

Though the UPL is an aggregate demonstration for state government owned or operated, non-state government owned or operated and private facilities, the data is presented for each clinic provider that receives Medicaid payments. This section describes the structure of the UPL data.

- The state is asked to assure that the UPL data demonstrates UPL compliance in the aggregate for state government-owned or operated facilities, non-state government owned or operated facilities, and privately owned or operated facilities. The state must demonstrate compliance distinctly for each category of clinic services. The designation of providers as state government-owned or operated facilities, non-state government owned or operated facilities, and privately owned or operated facilities must be consistent between UPL demonstrations.
- All clinic service providers that receive Medicaid payments under the applicable UPL service category must be included within the UPL calculations. We ask that states confirm the inclusion of all providers in the UPL demonstration.
- All Medicaid payments made to clinic service providers for services that are covered and paid under the clinic facility benefit category must be included in the demonstration. Base and supplemental payments should be separately identified.

VI. Source of Medicaid Payment Data

The Medicare estimate for equivalent Medicaid services is compared to the Medicaid payment data from the demonstration rate year. If the Medicaid payment data is at or below the Medicare estimate, the state’s clinic reimbursement methodology complies with the UPL regulations. The source, adjustments and exclusions applicable to the Medicaid payment data are described in this section.

- The Medicaid payment data should be from adjudicated Medicaid service claims from the MMIS. A check-box is provided to confirm that the source of the payment data is the MMIS. If the state uses a source other than the MMIS for the payment data, please explain the other source in the text box.
- The Medicaid payment data should be from the same date of service time period as the Medicaid charge and the Medicare cost report data. If the state uses a different Medicaid payment time period, we have asked the state to provide an explanation.
- States sometimes make base payments for clinic services and additional supplemental payments that are lump-sum adjustments or add-ons to the base payments. The UPL must include total clinic payments made to clinic providers (base and supplemental). State must identify the base and supplemental payments separately within the demonstration. If any payments are made outside of the MMIS, we ask the state to explain those payments in the text box that is provided.
- Consistent with the Medicaid charge data, we recommend that states exclude claims associated with services delivered to beneficiaries eligible for Medicare and Medicaid

(crossover claims), from the Medicaid payment data. There is a check box for state to confirm that cross-over claims are excluded.

- Consistent with the Medicaid charge data any adjustments to the Medicaid payment data should be noted in the methodology. If adjustments are made to the Medicaid payment data to consider primary care payments, deductibles and copays, adjustments should also be made to the Medicare payment data.
- As part of the calculation, states should make adjustments for changes in clinic payments that occurred between the demonstration period and the current rate year. For instance, if a state has implemented or intends to implement a new supplement payment, the amounts associated with the supplemental payment should be reflected in the Medicaid payment data.
- The amounts reported on the CMS-64 expenditure system for clinic payments should match or closely align with the amounts reflected in the base period for the UPL demonstration. We ask the state to verify the consistency with the reported expenditures and the UPL payment data and explain any inconsistencies.

VII. Trends and adjustments to the UPL Data

Because UPL calculations rely on data from prior periods, states often trend the data to the current rate year using inflationary and volume adjustments. In addition, states may use completion factors for charge and payment data to compensate for claiming lags. All trend sources and trending applications to the UPL data are described in this section.

- States should verify that trends are used for inflation and describe the inflationary trend source and application. CMS has accepted the Medicare economic index inflationary factor for clinic services as an appropriate UPL trend. The trend data should be applied as a “mid-point to mid-point” application in order to accurately project the trended historic data into the current rate year.
- Volume adjustments may be made to reflect changes in the Medicaid program that have occurred between the base and current rate year periods. The volume adjustment source should be based on data that reflects real program experience and the adjustment must be equally applied to the Medicaid payment and Medicare equivalent data. Within the narrative, states should verify that adjustments are used to account for increases (or decreases) in volume and describe the volume adjustment source and application.
- If the state adjusts UPL data using additional or alternative factors, we have requested an explanation and the basis for those adjustments in the text box provided.
- States occasionally apply completion factors to the Medicaid charge and payment data to account for lags in claims adjudication. The narrative requests that states indicate when claims completion factors are used for charge and payment data, the application of the factors and an assurance that the factors are applied consistently for the charge and payment data.

VIII. Clinic UPL demonstration requirements

States are required to demonstrate that, for each category of clinic providers (state government-owned or operated facilities, non state government-owned or operated facilities and privately-owned and operated facilities) payments do not, in the aggregate for each category, exceed the reasonable estimate of the amount that would be paid for the services furnished by the group of

facilities under Medicare payment principles. Verify that the state meets the clinic UPL demonstration requirements by selecting the appropriate check box. Note – state must provide supporting data by provider in a spreadsheet along with the description of the UPL methodology.

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.