Outpatient Hospital Narrative Instructions

I. The Basis of the UPL Formula

States generally demonstrate, and CMS has accepted as reasonable estimate of, the UPL based on a comparison of Medicaid payments to equivalent Medicare payment or Medicaid cost using Medicare principles. States may apply different UPL formulas for state government owned or operated, non-state government owned or operated and private facilities; however, the formula should be consistently applied to each provider within each category.

- Check-off boxes are provided for states to indicate if the demonstration is a cost based demonstration or a payment based demonstration.
- States that limit providers to actual incurred Medicaid cost and demonstrate the UPL using the incurred cost methodology should select the cost basis and detail the cost finding methodology in the narrative. Note that incurred Medicaid cost is typically found using Medicare cost principles but entails matching Medicaid charges to individual cost centers on the Medicare cost report (rather than using a single cost-to-charge ratio for each hospital).
- 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 be accepted by CMS.
- Within the formula a state should provide a high-level overview of the UPL calculations. For instance: (Medicare ancillary outpatient cost-to-charge ratio X Medicaid MMIS outpatient charge = Upper Payment Limit).

II. Source of the UPL Medicare Equivalent Data

This section describes the source of the data used to estimate a Medicare 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 upper payment limit, since the regulations describe the amount that Medicare would pay for equivalent Medicaid services.

- States may use either the more recently filed or settled CMS 2552 hospital cost report as the source of the Medicare data. Check-off boxes are provided to indicate if the cost reports are filed or settled.
- 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.
- To calculate a reasonable Medicare estimate, the data should be from cost reports that are from a reporting period that is no more two years prior to the current rate year.

States should indicate the time period of base year data (the cost report data) and the rate year data.

III. Cost Report References

Source data from the Medicare cost report is used to calculate cost-to-charge ratios or payment-to-charge ratios from the cost centers on the CMS 2552 that are used to report ancillary outpatient facility cost, payment and charge data. The specific cost report references are explained in this section.

For cost-based demonstrations:

- Ancillary outpatient cost to charge ratios are listed on worksheets C and D of the CMS 2552. Check-off boxes are provided for states to indicate whether worksheet C or D is used for a cost-based demonstration.
- States should specify the columns and lines from worksheet C or D that are used to determine the cost to charge ratio. A single cost-to-charge ratio for each demonstration hospital may be derived for a Medicare cost-based UPL demonstration – though as noted above more precision must be applied to UPLs that are limited to Medicaid cost.

For payment-based demonstrations:

- Worksheet E, part B (payments) and worksheet D, parts IV or V (charges) include the appropriate reporting lines to calculate outpatient payment to charge ratios. States will need to match the appropriate payment lines from worksheet E to the applicable charges from worksheet D. A text box is provided to specify the columns and lines used to determine payment-to-charge ratios. A single payment-to-charge ratio may be derived for each hospital facility within the demonstration.
- State should indicate whether the Medicare payment-to-charge data is reported as gross or whether adjustments are made to isolate the net Medicare payment amount.
- A text box is provided to describe the adjustments based on primary care payments, deductible, co-insurance and reimbursable bad debt that are made to determine the net Medicare payment amount.

For alternative demonstrations:

- A text box is provided to explain methodology that deviate from the standard Medicare cost report cost-to-charge or payment-to-charge references described above. Within the text box, states will need to describe the basis for deviating from the standard references, how the references are applied, and the basis for included additional or alternative cost reporting worksheets, columns or lines.

IV. Medicaid charge data

Medicaid adjudicated outpatient hospital facility charge data from each of the hospitals in the demonstration is applied to each hospital's specific cost-to-charge or payment-to-charge data. This determines a reasonable Medicare equivalent cost or payment amount for Medicaid equivalent services. The source, adjustments and exclusions applicable to the Medicaid charge data are described in this section.

- A check-off box is provided for states to indicate that the Medicaid charge data is reported to the MMIS. If the data is from another source, the state should indicate the source of the charge data. Note that CMS will request clarification of the basis for using data that is not adjudicated through the MMIS.
- The Medicaid charge data should be from the same dates of services as the cost reporting period used to derive the cost-to-charge or payment to charge ratios. This is important to ensure that the UPL is a reasonable estimate of Medicare payment since the hospital charges will be uniform for all payers for the reporting period. If the dates of services do no match states should provide an explanation of the discrepancy.
- Only charge data from in-state Medicaid residents should be included in the UPL calculation. This ensures that applied charges are not duplicative among state UPL demonstrations.
- CMS recommends that states exclude cross-over claims, for which Medicare is the primary payer, from the UPL calculation. A state's payment obligation for those claims is governed by the state's third party liability policies rather than the outpatient hospital reimbursement methodology. In addition, states have struggled to develop a Medicaid payment proxy for those claims that would reasonably compare to the Medicare equivalent estimate and not overstate the UPL. If a state selects that cross-over claims are included, we will need to discuss how the Medicare estimate is not overstated by the inclusion.
- The outpatient hospital benefit covers services billed and paid to outpatient hospital facility providers. Professional services that are covered, billed and paid under the Medicaid state plan should be excluded from the outpatient hospital UPL. States should confirm that professional services that are covered, billed and paid outside of the outpatient hospital state plan authority are excluded from the UPL calculation and explain the inclusion of any professional service charges.

V. 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 outpatient hospital 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 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.
- Many states make base payments for outpatient hospital services and additional supplemental payments that are lump-sum adjustments or add-ons to the base payments. The UPL must include total outpatient hospital payments made to outpatient hospital 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 cross-over 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 net 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 outpatient hospital 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 outpatient hospital 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.

VI. Trends and adjusts 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 outpatient 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.

VII. Analysis of clinical diagnostic laboratory services

Section 1903(i)(7) of the Social Security Act limits payments for Medicaid clinical diagnostic laboratory services to the amount that Medicare pays on a per test basis. The limit compares the Medicaid payment rate to the Medicare payment rate for each clinical diagnostic laboratory test covered under the Medicaid program. Since the tests are typically included in the outpatient hospital payment methodology, we ask that states conduct an analysis of the lab tests as part of the outpatient hospital upper payment limit demonstration. This section describes the state's analysis of compliance with section 1903(i)(7).

- Compliance with section 1903(i)(7) can be assured by indicating that state's reimbursement methodology reimburses a percentage of the Medicare payment rate for all Medicaid covered lab tests. A check box is provided for this assurance.
- If the state does not pay a percentage of the Medicare per test rates, we ask that the state submit data demonstrating that the Medicaid payments fall below the Medicare per test rates. State should indicate that they have provided this information in the data demonstration.
- If the clinical diagnostic lab service are included in the aggregate UPL demonstration state can either assure that the payment are consistent with section 1903(i)(7) or provide supporting data as part of the UPL demonstration. State should indicate that the clinical diagnostic lab services are factored into the UPL.

VIII. 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 hospital provider that receives Medicaid payments. This section describes the structure of the UPL data and the treatment of critical access hospital, which are paid at 101% of cost by Medicare.

- 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 hospital category. 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 Medicaid payments made to outpatient hospital facility providers for services that are covered and paid under the outpatient hospital benefit category must be included in the demonstration. Base and supplemental payments must be separately identified.
- All 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.
- States may include private facilities in the UPL calculation. If private facilities are included they must be included in the "private" hospital category.
- Critical access hospitals (CAHs) are paid 101% of cost by Medicare. Since these providers are paid on a different basis from other providers, state may deviate from the UPL formula used for other providers with a hospital category or separately calculate the UPL for CAHs. We request that the state indicate how CAHs are treated either within the outpatient hospital calculation or as a separate UPL calculation.