Guidance - Medicare Payment-Based Clinic UPL Demonstration

Introduction

States can demonstrate compliance with the clinic upper payment (UPL) limit specified in regulations at 42 CFR 447.321 by comparing cost to Medicaid payments or by comparing Medicaid fee schedule payments to Medicare payments. Medicare pays for services provided in the clinic setting using the non-facility Medicare Physician Fee Schedule (MPFS) rates. Therefore, for clinic demonstrations using *Medicare payment*, CMS requires that states use the non-facility Medicare rates to demonstrate compliance with the UPL requirements.

If a state pays for all clinic services at rates that are below Medicare, it need not include volume in its clinic UPL demonstration. A simple comparison of Medicaid rates to Medicare rates is sufficient. If Medicaid rates vary by clinic, the comparison should be provided at the facility level. Additionally, the state must either confirm that no supplemental payments are made to clinics or include both the Medicaid base and supplemental payments in the UPL demonstration.

Medicare does not pay for all of the services for which Medicaid pays; as a result, a direct comparison to posted rates is not always possible. We are therefore providing the following guidance to assist states in developing a fee schedule-based UPL.

1. *Medicare Physician Fee Schedule (MPFS)*

http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

Medicare rates are set by multiplying relative value units (RVUs) times a conversion factor times a geographic price cost index (GPCI). Each year, effective January 1, the MPFS is updated to include the new conversion factor, RVUs and any changes to the GPCI. Medicare publishes the MPFS online at the above address. States can use this tool to find Medicare rates for the CPT and HCPCS codes paid by Medicare. For services without a Medicare rate, states may use options 2 & 3 below.

2. *Using RVUs to construct the "Medicare" Rates*

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Each year when Medicare publishes the rates for the MPFS, it also publishes the working files used for rate setting. This includes the RVUs, GPCIs, and the Medicare conversion factor. Once those values have been identified, States may calculate their own Medicare-equivalent rates using the following formula:

Non-Facility Rate = [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor

All of the components can be found at the link above. They are sorted by year. The RVUs and conversion factors can be found in the PPRRVU files and the GPCIs can be found in the GPCI files found in the download section of the website. Medicare will assign values to most of the RVUs, including some that are not payable on the MPFS. However, some of the CPT and HCPCS codes in these files *are not assigned RVU values.* For those remaining codes, states should proceed to step 3.

3. Finding Medicare Equivalent Codes

For CPT and HCPCS codes that are not assigned a rate on the MPFS or an RVU in the above mentioned RVU publication, States must crosswalk these codes to other CPT or HCPCS codes that **represent a similar service or medical procedure** and also have either a payment rate on the MPFS or an RVU. CMS recommends that States use the RVU listing to find codes that have a similar description/nature, intensity, and complexity as the service in question. Once a code with an RVU is found, the State may either locate the rate in the MPFS or use the formula described in section 2 to calculate a Medicare-equivalent rate.

Encounter or Visit Rates

States that pay for services provided in clinics using bundled encounter or visit rates must separate those bundled rates into component parts that can then be compared to Medicare rates as described above. As previously indicated, component parts of the Medicaid must represent **similar medical procedures/services** to the crosswalked Medicare rate. States may not use Medicare charges and Medicaid charges to identify "similar" services.

Clinic UPL example using the steps defined in this document:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
					(4) * (5)			Medicare Rate * Units
CPT Code	Units Of Service	Medicare Non-Facility Rate	Calculation for codes with no Medicare Rate*			Medicare-like Code		Est Medicare Expend (UPL)
			Non-Facility PE RVU CY2013	MPFS Conversion Factor CY 2013	Medicare RVU * Conversion Factor	Medicare Equivalent Code (CPT)	Medicare Equivalent Rate	
				$	$	(cpt)	$	$ 152,600.72
		$	1.95	$ 34.02	$ 66.35	(cpt)	$	$ 9,023.60
		$	$	$	$	90471	$ 28.25	$ 6,045.50
								$167,669.82

* States may include *Geographic Practice Cost Index* to account for local price variation as defined in Section #2.
($) and (cpt) are just placeholders

General Guidance for Crosswalks using the Above Example:

- <u>CPT Code 99201: Outpatient/Office Visit</u> - Medicare publishes a rate for this service on the Medicare Physician Fee Schedule. Use this rate as applicable.

- <u>CPT Code 99386: Preventative Visit for a New Patient Ages 40-64</u> - Medicare only publishes an RVU for this code, but does not include a rate for this service on their fee schedule likely due to the age of eligibility for Medicare. It is likely that a State could just as easily find an equivalent code for a preventative visit for a new patient within a different age bracket.

- <u>CPT Code 90649: HPV Vaccine Administration</u> – Medicare does not publish a Physician Fee Schedule rate or an RVU for the HPV vaccine. This State opted to use CPT Code 90471 which is a generic code for the Administration of an Immunization, which is covered under the Medicare Physician Fee Schedule.

Ambulatory Surgical Centers (ASCs)

ASCs are reimbursed according to a Medicare fee schedule published each year under the Medicare regulations. The rates are set for each HCPCS code listed under the fee schedule. Many states simply use the same HCPCS codes and set state-specific rates for those codes. To demonstrate a UPL for ASCs, the method follows closely to that which is described above, but with a slight variation on the underlying Medicare data sources. To locate the Medicare ASC fee schedule, follow the below steps (directions are meant as an illustration, so start from step one and follow directions. *Links after Step 1 are only for 2015*):

1. Go to the "ASC Regulations and Notices" page on CMS.gov: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html

2. Find the "Final Rule with Comment Period" for the particular fiscal year the state is considering from the listing found on that page (for purposes of this demonstration, we will use 2015 as the period). Select the appropriate hyperlink. Note: all "Final Rule will Comment Period" hyperlinks are denoted with an "FC" at the end of the file name. For example, 2015 is "CMS-1613-FC".

3. This will take you to the landing page of the final rule and the supporting documentation. http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1613-FC.html?DLPage=1&DLSort=2&DLSortDir=descending

4. Scroll to the bottom of the page to the "Related Links" section and select the Link entitled "Addendum AA, BB, DDI, DD2, and EE." You will be directed to a license agreement page: http://cms.gov/apps/ama/license.asp?file=/ascpayment/downloads/CMS-1613-FC-ASC-Addenda-AA-BB-DD1-DD2-EE.zip

5. Click "Accept" and a zip file will open.

6. Open the Excel documented. For 2015 it is entitled "FR 2015 ASC Addenda AA-BB-DD1-DD2-EE.10312014.xlsx" - **This is the Medicare ASC fee schedule for 2015.** The rate listed under

"Final CY 2015 Payment Rate" is the Medicare rate for the particular HCPCS code in the ASC. The rates in this fee schedule are the **national** rates. Medicare-defined locality adjustments can be applied if the State elects to do so for the UPL demonstration.

HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Final CY 2015 Comment Indicator	Final CY 2015 Payment Indicator	Final CY 2015 Payment Weight	Final CY 2015 Payment Rate
10021	Fna w/o image	Y	CH	P3	(empty)	$99.17

End Stage Renal Disease (ESRD) Clinics

Each year when Medicare publishes its final rule CMS also publishes a provider level impact file. The data is developed by simulating what payments would look like for the following rate year based on the provisions in the regulation. This is useful for states because they can pull all of the providers located in their state and calculate the projected average payment per treatment, which would include wage, case-mix, and facility level adjustments.

1. Go to the following website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html

2. Select the "Final Rule" link of the ESRD Payment Regulations and Notices Page. The final rule is denoted by an "F" at the end of the regulation number. For example, the 2015 file is entitled "CMS-1614-F."

3. Once on the final rule details page, under the "Downloads" section, select the "CY 2015 ESRD PPS Facility Level Impact File (ZIP)."

4. On that list you will find the estimated total ESRD treatments (Column B) and the estimated total payments under PPS (Column I).

5. Using the provider numbers, States should identify providers located in their state and sum Column I (Estimated total MAP - assuming all providers were 100% ESRD PPS) for those providers and divide by the sum of Column B (which is, hemo-equivalent treatments) for the same facilities to get the projected average payment per treatment for the state. This can then be compared to Medicaid's rate for ESRD services.

Provider ID	Dialysis treatments	PMT 2013	PMT OUTLIER	PMT WIBN	PMT BLEND	PMT MB	PMT TAON	PMT FINAL
0XXX00	12,869	3,109,299	3,136,735	3,084,269	3,084,269	3,168,662	3,168,740	3,066,382

PMT Final / Dialysis Treatments = AVG Payment per Treatment
$ 3,066,382 / 12,869 = $ 238.28

Clinical Diagnostic Laboratory Services (CDL)

In accordance with 1903(i)(7) of the Social Security Act, Medicaid payments for CDL services are limited to what Medicare pays on a per test basis, not to payments in the aggregate. States that find that they are not in compliance the statute must recoup overpayments in a timely manner and modify their fee schedules to prevent future overpayments.

CDLs are reimbursed according to a Medicare fee schedule published annually under the Medicare regulations. The rates are set for each HCPCS code listed under the fee schedule. Many states simply use the same HCPCS codes and set state-specific rates for those codes. To demonstrate a UPL for CDLs, the method follows closely to that which is described above, but with a slight variation on the underlying Medicare data sources. To locate the Medicare CDL fee schedule, follow the below steps (directions are meant as an illustration, so start from step one and follow directions. *Links after Step 1 are only for 2015*):

1. Go to the Clinical Diagnostic Fee Schedule Page on CMS.gov:
http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html

2. In the "Related Links" Section, find the file that matches the year of the demonstration. As an example, we will use 2015 which is under the link entitled "15CLAB". Select this link and you will be taken to a License Agreement landing page. Click "Accept" to open a zip file.

3. Open the file entitled: "CLAB2015.EffJan1.Full.Updt.xls"

4. This file contains the CDL rates by HCPCS codes. It also contains a "National Limit" which is the median national rate for the services. Columns F through BJ are the rates for each Locality that is recognized by Medicare. States can either use the national limit or search for specific locality/localities to demonstrate the UPL – as you can see below, there isn't always a difference.

HCPCS	Modifier	National Limit	Mid-Point	Floor	HI 01212 LOC 00
36415	0.00	0.00	0.00	0.00	3.00
78267	0.00	10.70	14.46	0.00	10.70
78268	0.00	91.66	123.87	0.00	91.66

Median National Rates   Locality Specific Rates