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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 16-0013

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

November 27, 2017

Mr. Joshua Baker
Interim Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

RE: Title XIX State Plan Amendment, SC 16-0013

Dear Mr. Baker:

We have reviewed the proposed State Plan Amendment, SC 16-0013, which was submitted to the Atlanta Regional Office on December 2, 2016. This plan amendment effective October 1, 2016, expands South Carolina (SC) rural hospital definition to include a SC hospital that is located within a "persistent poverty county" as defined in Public Law (P.L.) 112-74. This plan also modifies the allowable cost settlement percentages for outpatient hospital reimbursement for those qualifying hospitals eligible to receive retrospective cost settlements. Specifically, the following changes are being implemented: (1) hospitals designated as SC defined rural hospitals or qualifying burn intensive care unit hospitals prior to October 1, 2014 will now receive 100% of their SC Medicaid allowable outpatient reimbursable costs subject to the July 1, 2014 and October 1, 2015 normalization actions; (2) hospitals designated as rural hospitals or as qualifying burn intensive care unit hospitals by the SC Medicaid Program for the first time effective on and after October 1, 2014 will now receive the greater of actual Medicaid reimbursement or 90% of their SC Medicaid allowable outpatient reimbursable costs but not to exceed 100% of their SC Medicaid allowable outpatient reimbursable costs and; (3) SC hospitals designated as rural or as a qualifying burn intensive care unit hospital by the SC Medicaid Program for the first time effective on and after October 1, 2016 will receive the greater of actual Medicaid reimbursement or 80% of their SC Medicaid allowable outpatient reimbursable costs but not to exceed 100% of their SC Medicaid allowable outpatient reimbursable costs.

Based on the information provided, the Medicaid State Plan Amendment SC 16-0013 was approved on November 27, 2017. The effective date of this amendment is October 1, 2016. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Cheryl Wigfall at (803) 252-7299.

Sincerely,

//s//

Shantrina Roberts
Acting Associate Regional Administrator
Division of Medicaid & 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: 16-0013

2. STATE: South Carolina

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
October 1, 2016

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:
42 CFR Part 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 $ Budget Neutral
b. FFY 2018 $ Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B pages, 1.1, 1a.3, 1a.6, 1a.7, 1a.8, 1a.9 (New Page)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B pages, 1.1, 1a.3, 1a.6, 1a.7, 1a.8

10. SUBJECT OF AMENDMENT:
New criteria for SC defined rural hospitals as well as tiered cost settlement payment methodologies.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Soura was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Christian L. Soura

14. TITLE:
Director

15. DATE SUBMITTED:
December 2, 2016

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/02/16

18. DATE APPROVED: 11/27/17

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/16

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Shantrina Roberts

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS: Approved with the following changes to block 8 and 9 as authorized by the state on email dated 11/17/17.

Block# 8 changed to read: Attachment 4.19-B pages 1.1, la.3, la.4, la.6, la.7, la.8, la.9 and la.10 (new)
Block# 9 changed to read: Attachment 4.19-B pages 1.1, la.3, la.4, la.6, la.7, la.8, and la.9

FORM HCFA-179 (07-92)

- For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after October 1, 2015, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 65th percentile of the October 1, 2014 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 15th percentile, these hospitals will be reimbursed at the 15th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 15th percentile will continue to receive its October 1, 2014 hospital specific outpatient multiplier.

  For hospitals that are eligible to receive retrospective cost reimbursement and fall under the 15th percentile, these hospitals will be eligible to receive Medicaid outpatient hospital reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost settlement and are capped by the 65th percentile methodology will be reimbursed the lower of allowable actual Medicaid reimbursable outpatient hospital costs or Medicaid outpatient hospital payments at the 65th percentile for services provided on or after October 1, 2015.

- Effective for outpatient hospital services provided on or after October 1, 2014, the South Carolina Department of Health and Human Services has updated its current designation of South Carolina (SC) defined rural hospitals with the following SC defined rural hospital criteria:

  SC defined rural hospitals will include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with 130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with 90 Licensed Beds. ZCTAs are classed as Rural or Urban based on their population designations as defined by the 2010 Census. Each rural/urban classification reflects the relative proportion of ZCTA residents living in rural versus urban areas. These classifications are as follows.

    - Urban: 80.0% to 100.0% Urban
    - Moderately Urban: 60.0% to 79.9% Urban
    - Equally Rural/Urban: 40.1% to 59.9% Rural/Urban
    - Moderately Rural: 60.0% to 79.9% Rural
    - Rural: 80.0% to 100.0% Rural

  The percentage of the population that is not Urban is considered Rural by the US Census.

  Effective October 1, 2016, an additional SC defined rural hospital criterion was created to include a SC hospital that is located within a ''persistent poverty county'' as defined in Public Law (P.L.) 112-74 that is not otherwise eligible for higher reimbursement.

Effective for outpatient hospital services provided on or after October 1, 2014, the South Carolina Department of Health and Human Services has updated its current designation of South Carolina (SC) defined rural hospitals with the following SC defined rural hospital criteria:
SC defined rural hospitals will include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds. ZCTAs are classed as Rural or Urban based on their population designations as defined by the 2010 Census. Each rural/urban classification reflects the relative proportion of ZCTA residents living in rural versus urban areas. These classifications are as follows:

- Urban: 80.0% to 100.0% Urban
- Moderately Urban: 60.0% TO 79.9% Urban
- Equally Rural/Urban: 40.1% to 59.9% Rural/Urban
- Moderately Rural: 60.0% to 79.9% Rural
- Rural: 80.0% to 100.0% Rural

The percentage of the population that is not Urban is considered Rural by the US Census.

Effective October 1, 2016, an additional SC defined rural hospital criterion was created to include a SC hospital that is located within a ''persistent poverty county'' as defined in P.L. 112-74 that is not otherwise eligible for higher reimbursement.

Therefore, effective for services provided on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multiplier for all SC general acute care hospitals that qualify as rural as well as qualifying burn intensive care unit hospitals was increased by 2.50%. However, for SC general acute care teaching hospitals as defined in Attachment 4.19-A, the DME portion of the hospital specific outpatient multiplier was not subject to the 2.50% increase.

Hospital Specific Outpatient Multiplier Calculation Effective On and After November 1, 2012

The following methodology is employed in the computation of the hospital specific outpatient multiplier effective November 1, 2012:

a) The hospital specific outpatient multipliers will continue to be calculated so that outpatient hospital reimbursement approximates the Department's specified percent of allowable Medicaid costs for each eligible hospital as described under the section titled ''Determination of Hospital Specific Outpatient Multipliers''.

b) A cost to charge ratio will be calculated for Medicaid outpatient hospital services. This ratio will be calculated using cost from worksheet B Part 1 Column 24, charges from worksheet C Column 8, and Medicaid cost settled ancillary charges obtained from the Medicaid Management and Administration Reporting System (MARS) identified on worksheet D part V column 3. The Medicaid outpatient hospital cost-to-charge ratio will be determined by taking the sum of the SC Medicaid outpatient ancillary costs and dividing this amount by the sum of the SC Medicaid covered outpatient ancillary charges. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation. Effective for services provided on or after July 11, 2011, two cost to charge ratios will be determined for teaching hospitals. The first cost to charge ratio will be determined on base and all capital related costs except those associated with DME capital costs using the methodology previously described. The second cost to charge ratio will be determined using DME costs only (including the capital portion of DME Costs) using the methodology previously described. The applicable reductions (i.e. 93% or 97% to base and capital and 100% or 87.3% to DME) will be applied to the calculated cost for each cost pool and an adjusted cost/charge ratio will be determined.

c) Next, each hospital's cost to charge ratio will be further adjusted upward or downward for the effect of the Hospital Fiscal Year (HFY) 2010 audit adjustment factor. The HFY 2010 audit adjustment factor is determined by dividing the audited HFY 2010 Medicaid outpatient cost to charge ratio by the interim adjusted HFY 2010 Medicaid outpatient hospital cost to charge ratio.

d) The adjusted hospital fiscal year 2011 Medicaid outpatient hospital cost to charge ratio for each hospital, as described above in b) and c), is multiplied by each hospital's Medicaid outpatient hospital allowed charges based upon services provided during the period October 1, 2011 through June 30, 2012.

e) The Medicaid allowable outpatient cost determined in d) above is reduced by one and a half percent (1.5%) to determine the cost target to be used for each eligible hospital to receive a hospital specific outpatient multiplier. The one and a half percent reduction is applied to take into account the difference between the cost report year and the claims data period.

f) The Medicaid cost target for each hospital determined in e) above will then be compared to each hospital's corresponding base Medicaid fee for service claims payments (including co-pay and TPL) prior to the application of the hospital specific outpatient multiplier in effect during the payment period outlined in d) above to determine the hospital specific outpatient multiplier effective November 1, 2012. To determine the base Medicaid fee for service claims payments for services provided on and after October 1, 2011 during the October 1, 2011 through June 30, 2012 claims payment period prior to the application for the hospital specific outpatient multiplier, the claim payments for this period are divided by the October 1, 2011 hospital specific outpatient multiplier. A further adjustment to base Medicaid fee for service claims revenue was made for a 75% reduction in OP therapy rates.

g) Effective for services occurring on or after October 1, 2013, the November 1, 2012 hospital specific outpatient multiplier was increased by 2.75% for all SC general acute care non-teaching hospitals and qualifying out of state border general acute care teaching and non-teaching hospitals. Effective for services occurring on or after October 1, 2013, the November 1, 2012 hospital specific outpatient multiplier for all SC teaching hospitals as defined by Attachment 4.19-A was increased by the proportion of Medicaid outpatient DME costs to total Medicaid outpatient costs (including DME) multiplied by 2.75%. For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after July 1, 2014, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 75th percentile of the October 1, 2013 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 10th percentile, these hospitals will be reimbursed at the 10th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific

(Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 15th percentile, these hospitals will be reimbursed at the 15th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 15th percentile will continue to receive its October 1, 2014 hospital specific outpatient multiplier. For all other hospitals that did not receive a hospital specific outpatient multiplier, an outpatient multiplier of .93 will be assigned to those hospitals. The hospital specific outpatient multiplier determined above will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability and coinsurance.

Clinical Lab Fee Schedule:

Effective October 1, 2010, all outpatient hospital clinical lab services provided by governmental and private hospitals will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after October 1, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data and qualifying burn intensive care unit hospitals will be reimbursed at ninety-seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Therefore, the hospital specific outpatient multiplier described above will no longer be applied in the determination of outpatient hospital clinical lab services reimbursement.

Retrospective Hospital Cost Settlement Methodology:

Effective October 1, 2013, the following methodology describes the outpatient hospital retrospective cost settlement process for qualifying hospitals. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred percent (100%) of the South Carolina General acute care hospital provider tax will be considered an allowable Medicaid costs. Effective October 1, 2010, outpatient hospital clinical lab services will no longer be retrospectively cost settled.

- A cost to charge ratio will be calculated for Medicaid outpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, and Medicaid settlement data from worksheet D part V. For ancillary cost centers, a cost-to-charge ratio will be calculated by dividing cost as reported on worksheet B part I by total charges from worksheet C. Medicaid cost for each ancillary cost center will be determined by multiplying this ratio by Medicaid charges as reported on worksheet D part V. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation.

- Total allowable Medicaid cost will be determined at the time of cost settlement by multiplying the adjusted cost to charge ratio as calculated above, by Medicaid charges.

- The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable cost determined above. The payment amount includes Mars report payments and non Mars Report adjustments that were processed during the cost reporting/settlement period. Examples of these adjustments are interim cost settlement payments, etc.

- Effective for services provided on or after July 1, 2014, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10th percentile will be eligible to receive Medicaid outpatient reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 75th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable outpatient hospital costs or Medicaid outpatient hospital payments at the 75th percentile of the base rate component for services provided on or after July 1, 2014.

- Effective for services provided on or after October 1, 2015, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 15th percentile will be eligible to receive Medicaid outpatient reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 65th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable outpatient hospital costs or Medicaid outpatient hospital payments at the 65th percentile of the base rate component for services provided on or after October 1, 2015.

- Effective for outpatient hospital services provided on or after October 1, 2016, qualifying hospitals eligible to receive retrospective cost settlements (i.e. SC defined rural hospitals and qualifying burn intensive care unit hospitals) will receive tiered Medicaid reimbursement as follows:

    - Hospitals designated as SC defined rural hospitals or qualifying burn intensive care unit hospitals prior to October 1, 2014 will receive 100% of their SC Medicaid allowable outpatient reimbursable costs subject to the July 1, 2014 and October 1, 2015 normalization actions;

    - SC hospitals designated as rural hospitals or as qualifying burn intensive care unit hospitals by the SC Medicaid Program for the first time effective on and after October 1 ,2014 will receive the greater of actual Medicaid reimbursement or 90% of their SC Medicaid allowable outpatient reimbursable costs but not to exceed 100% of their SC Medicaid allowable outpatient reimbursable costs;

    - SC hospitals designated as rural or as a qualifying burn intensive care unit hospital by the SC Medicaid Program for the first time effective on and after October 1, 2016 will receive the greater of actual Medicaid reimbursement or 80% of their SC Medicaid allowable outpatient reimbursable costs but not to exceed 100% of their SC Medicaid allowable outpatient reimbursable costs.

For clarification purposes, all interim retrospective cost settlements will be subject to final audit. Any underpayment/(overpayment) identified as a result of the final audit will be paid or recouped accordingly.

II. Upper Payment Limits:

Outpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements defined in 42 CFR 447.321.

Non-State Owned Governmental and Private Outpatient Hospital Service Providers

The following methodology is used to estimate the upper payment limit applicable to non-state owned governmental and privately owned or operated outpatient hospitals (i.e. for profit and non-governmental nonprofit facilities). State owned psychiatric hospitals do not provide outpatient hospital services so no UPL demonstration is warranted for this class:

The most recent HFY 2552-10 cost report serves as the base year cost report to be used for Medicaid UPL calculations. In order to determine the Medicare allowable cost using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

(1) Medicaid covered outpatient hospital ancillary charges are obtained from the Summary MARS outpatient hospital report. Data source - Summary MARS outpatient hospital report.

(2) Medicaid covered outpatient hospital ancillary cost is determined by multiplying covered Medicaid outpatient hospital ancillary charges as identified on worksheet D Part V, column 3, lines 50 thru 117 by the ancillary cost to charge ratios as reflected on worksheet C, column 8, lines 50 thru 117. Data source - HFY 2552-10 cost report.

(3) The total Medicaid outpatient hospital cost determined in step (2) is then trended using the mid-year to mid-year inflation method and the use of the 4th Quarter 2015 Global Insight Indexes - 2010 Based CMS hospital PPS Market Basket in order to trend the base year cost (HFY 2015) to the Medicaid rate period October 1, 2016 through September 30, 2017.

(4) Total base year Medicaid outpatient hospital revenue is derived from each hospital's Summary MARS report based upon each hospital's cost reporting period. Data source - Summary MARS outpatient hospital report.

(5) Next, the Department divided the Medicaid outpatient hospital revenue for each hospital by the weighted average hospital specific outpatient multipliers based upon the October 1, 2013, July 1, 2014, October 1, 2014 and October 1, 2015 multipliers to determine the Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year period.

(6) Next, the Department multiplied the October 1, 2016 hospital specific outpatient multipliers against the Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year (see step (5))to determine projected Medicaid outpatient hospital revenue for FFY 2017. For hospitals that continue to receive retrospective cost settlements at 100% of allowable costs on and after October 1, 2016, the estimated revenue for the FFY 2017 payment period equals the trended inflated cost as described in step (3) subject to the exceptions granted in the October 1, 2015 normalization action.

(7) The Medicaid UPL compliance check is determined for each class by comparing the aggregate amounts as determined in (3) above to ensure that projected Medicaid outpatient hospital cost is equal to or greater than projected Medicaid outpatient hospital payments. In the event that aggregate Medicaid outpatient hospital payments exceed aggregate Medicaid outpatient hospital cost, the hospital specific outpatient multiplier for each facility will be established using the Medicaid cost as reflected in step (3).

Cost Report Requirements:

Cost report requirements under the prospective payment system and retrospective reimbursement system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - CMS-2552. In addition, providers must comply with Medicaid specific cost report requirements as published by the DHHS.

All cost report financial and statistical information, the medical information contained on claims and information contained on supplemental worksheets such as the DSH survey, are subject to audit by the DHHS or its designee. The audited information will be used for future rate calculations, retrospective cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

Co-payment Requirements:

Emergency services are not subject to co-payment. The outpatient cost settlement payment calculation will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

B. Objectives

Implementation of the reimbursement methodology provided herein has the following objectives: