

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Singleton/Chavis</i>	DATE <i>4-2-15</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000222</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>CC: Kost, Deps, CMS file</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

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

March 30, 2015

Mr. Christian L. Soura
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

RECEIVED

APR 02 2015

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Attention: Sheila Chavis

RE: Title XIX State Plan Amendment, SC 12-025

Dear Mr. Soura:

We have reviewed the proposed State Plan Amendment, SC 12-025, which was submitted to the Atlanta Regional Office on December 21, 2012. This amendment eliminates outpatient hospital retrospective cost settlements for most hospitals as well as updates the hospital specific outpatient multiplier.

Based on the information provided, the Medicaid State Plan Amendment SC 12-025 was approved on March 30, 2015. The effective date of this amendment is November 1, 2012. 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 or Stanley Fields at (502) 223-5332.

Sincerely,

A handwritten signature in cursive script that reads 'Jackie Glaze'.

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
SC 12-025

2. STATE
South Carolina

FOR: HEALTH CARE FINANCING ADMINISTRATION

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
November 1, 2012

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

7. FEDERAL BUDGET IMPACT: O/P multipliers are expected
to approximate allowable Medicaid cost.

a. FFY 2013 \$
b. FFY 2014 \$

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Pages 1, 1.1, 1a, 1a.1, 1a.2, 1a.3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Attachment 4.19-B, Pages 1, 1.1, 1a, 1a.1, 1a.2, 1a.3

10. SUBJECT OF AMENDMENT:

Elimination of retrospective cost settlements for most hospitals effective 11/1/12 and hospital specific outpatient multiplier update effective 11/1/12.

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. Keck was designated by the Governor
to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
December 18, 2012

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: 12/21/12

18. DATE APPROVED: 03/30/15

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
11/01/2012

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:
Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS: Approved with the following changes to block #8 as authorized by state agency in the RAI response dated:02/03/15
Block #8 changed to read: Attachment 4.19-B pages 1, 1.1, 1a, 1a.1, 1a.2, 1a.3, 1a.4 and 1a.5

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE
(Reference Attachment 3.1-A)

2.a. OUTPATIENT HOSPITAL SERVICES

I. General Provisions

A. Outpatient Hospital Reimbursement and Upper Payment Limit (UPL) Provision

This plan establishes the methods and standards for reimbursement of outpatient hospital services effective November 1, 2012. Under this plan, a retrospective reimbursement system will be available for the following qualifying hospitals:

- Effective for services provided on or after November 1, 2012, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and Direct Medical Education (DME) costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will continue to receive ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.
- Effective for services provided on or after November 1, 2012, 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 will receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.
- Effective for services provided on or after November 1, 2012, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital, and DME costs. In order for a hospital to qualify under this scenario, a hospital must:
 - a. Be located in South Carolina or within 25 miles of the South Carolina border;
 - b. Have a current contract with the South Carolina Medicaid Program; and
 - c. Have at least 25 beds in its burn intensive care unit.

Determination of the Statewide Outpatient Hospital Fee Schedule Rates:

The October 1, 2007 statewide outpatient hospital fee schedule rates for acute care and long term acute care hospitals will be based upon

SC: 12-025
EFFECTIVE DATE: 11/01/12
RO APPROVAL: 03/30/15
SUPERCEDES: SC 11-024

the allowable outpatient cost information of covered services from each acute care hospital's FY 2005 cost report. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published on the agency's website. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims were used in this analysis. 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 cost. Outpatient allowable costs, charges and statistics will be extracted from the cost report and prepared for the rate computations using the following general guidelines. The FY 2005 SCDHHS Management and Administration Reporting System (MARS) paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

- As filed total facility costs are identified from each facility's FY 2005 Worksheet B Part I (BI) CMS-2552 cost report. Total outpatient facility costs would include operating, capital, and direct medical education. CRNA costs identified under BI, column 20 are removed from allowable costs. Observation cost is reclassified.
- As filed total facility costs will be allocated to Medicaid outpatient hospital cost using the following method:

A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges (as reported on Worksheet D Part V for Medicaid outpatient ancillary charges) to yield total SC Medicaid outpatient ancillary costs. The SC Medicaid outpatient 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 outpatient covered ancillary charges. The SC Medicaid outpatient cost-to-charge ratio will then be multiplied by the facility's SC Medicaid covered outpatient charges as identified on the SCDHHS MARS summary paid claims data report to determine each hospital's allowable SC Medicaid outpatient cost for FY 2005.

- The allowable Medicaid outpatient costs are summed to determine the aggregate Medicaid outpatient costs for FY 2005. An aggregate Medicaid allowable cost target was established at 95% of allowable Medicaid outpatient costs.
- After establishing the FY 2005 aggregate Medicaid allowable cost target, several actuarial models were developed and FY 2005 outpatient claims were repriced to determine the uniform increase in the statewide outpatient fee schedule rates. In order to trend the rates to the period October 1, 2007 through September 30, 2008, a 3.5% annual trend factor was applied. As a result of these steps, the statewide outpatient fee schedule rates increased by 135% effective October 1, 2007.

Determination of Hospital Specific Outpatient Multipliers:

In order to convert the statewide outpatient fee schedule rate payment into a hospital specific payment, an outpatient multiplier will be developed for each hospital. The outpatient multiplier will adjust the calculated statewide outpatient fee schedule claims payment to a hospital specific payment and will represent the projected outpatient costs calculated in accordance with Agency defined criteria effective November 1, 2012 and incorporate the impact of the July 11, 2011 payment reductions for the classes of hospitals outlined in this and the following three paragraphs. Hospitals that receive a hospital specific outpatient multiplier will be those eligible to receive retrospective cost settlements and those SC general acute care hospitals that no longer are eligible to receive retrospective cost settlements effective for services provided on or after November 1, 2012 as well as contracting out of state border hospitals that have S C Medicaid fee for service inpatient claims utilization of at least 200 claims.

Effective for services provided on or after November 1, 2012, all SC general acute care hospitals except those designated 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 and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 93% of allowable Medicaid targeted base costs less Direct Medical Education (DME)). Additionally, the hospital specific multipliers of the SC general acute care hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for the allowance of eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).

Effective for services provided on or after November 1, 2012, contracting out of state border hospitals that have SC Medicaid fee for service claim utilization of at least 200 claims will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 93% of allowable Medicaid targeted base costs less DME). Additionally, the hospital specific outpatient multipliers of the out of state border hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for DME costs (including the capital related costs) no longer being reimbursed to contracting out of state border hospitals.

Effective for services provided on or after November 1, 2012, all SC general acute care hospitals designated 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 and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 97% of allowable Medicaid targeted costs including DME).

Hospital Specific Outpatient Multiplier Calculation Effective 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) For all other hospitals that did not receive a hospital specific outpatient multiplier, an outpatient multiplier of .93 will be assigned to those hospitals.
- h) The hospital specific outpatient multiplier determined above (step f) 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 total licensed beds of 90 or less 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 total licensed beds of 90 or less 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 November 1, 2012, 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. The cost to charge ratio will then be multiplied by 97% to take into account the April 8, 2011 payment reductions that apply to the hospitals that have been exempted from the July 11, 2011 payment reductions.
- 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.

SC 12-025
EFFECTIVE DATE: 11/01/12
RO APPROVAL: 03/30/15
SUPERCEDES: SC 11-024

- The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable adjusted 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.

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.

Upper Payment Limits:

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 2012 2552-10 cost report serves as the base year cost report to be used for Medicaid rate setting and 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 that were determined using total cost from worksheet B Part I column 24 and total charges from worksheet C, column 8. 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 Global Insight 2010 CMS Hospital Prospective Reimbursement Market Basket Index First Quarter 2014 in order to trend the base year cost (HFY 2012) to the Medicaid rate period October 1, 2012 through September 30, 2013.
- (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, to account for the physical and occupational therapy rate changes since the base year, the Department reduced the base year outpatient hospital payments by 75% of the physical and occupational therapy payments received by the hospital during the base year. Next, the Department took the Medicaid outpatient hospital revenue as reflected in step (4) and reduced this amount by the impact of the June 1, 2012 PT and OT rate changes. Next, the Department divided the adjusted Medicaid outpatient hospital amount for each hospital by the October 1, 2011 hospital specific outpatient multiplier to arrive at the actual/adjusted Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year period.
- (6) Next, to account for the November 1, 2012 hospital specific outpatient multiplier update, the Department multiplied the November 1, 2012 hospital specific outpatient multipliers against the adjusted Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year (see step (5)). Because the hospital specific outpatient multiplier changed November 1, 2012, only 11 months of the annual projected November 1, 2012 estimated revenue is allowed. However, to account for projected October 2012 outpatient hospital revenue for hospitals eligible for retrospective cost settlement prior to November 1, 2012, the Department applied 1/12th of the Total Medicaid trended cost as determined in step (3) above and multiplied this amount by the applicable cost settlement percentage (i.e. 97%, 93%, or teaching hospital specific %) for each hospital. For hospitals that continue to receive retrospective cost settlements at 97% of allowable costs on and after November 1, 2012, the estimated revenue for the October 1, 2012 through September 30, 2013 payment period equals the trended inflated cost as described in step (3) multiplied by 97%. For hospitals that were not eligible to receive retrospective cost settlements prior to November 1, 2012, the October 1, 2012 through September 30, 2013 Medicaid revenue was estimated to equal the annual revenue based upon the application of the November 1, 2012 Medicaid outpatient multiplier against the adjusted statewide outpatient fee schedule payments (step 5).

- (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 rate expenditures in step (6). In the event that aggregate Medicaid outpatient hospital rate expenditures 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).

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

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:

Brenda James

From: Sheila Chavis
Sent: Monday, March 30, 2015 2:43 PM
To: Brenda James
Cc: Jan Polatty; Christian L. Soura
Subject: FW: SC-12-025
Attachments: SC-12-025, Approval Letter, 179 and Plan Pages.pdf; Attachment 4 19-B pages 1 1 1 1a 1a 1 1a 3 1a 4 1a 5 (no tracking) w add'l edits to page 1a 3 to 3 26 15.docx

Brenda,
Please log this if we do not receive the hardcopy in a few weeks. This will not require an action date because it is an approval packet. Thanks!

Sheila Chavis

Public Information Director I

CHAVISS@scdhhs.gov

803.898.2707 / 803.898.2707

cell: 803.521.2903

1801 Main Street

Columbia, South Carolina - 29202-8206

www.scdhhs.gov



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From: Holly, Mary V. (CMS/CMCHO) [<mailto:Mary.Holly@cms.hhs.gov>]
Sent: Monday, March 30, 2015 2:32 PM
To: Sheila Chavis
Cc: Wigfall, Cheryl (CMS/CMCHO); Drake, Maria (CMS/CMCHO); Lewis, Clarence (CMS/CMCHO); Hinson, David D. (CMS/CMCHO)
Subject: SC-12-025

Attached are the approval documents for SC-12-025. The original will be mail today.

* Hard Copy came in
4-2-15

Hold until
hard copy
come in.
3/30/15

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

March 30, 2015

RECEIVED

MAR 30 2015

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. Christian L. Soura
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

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Sincerely,

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Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

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STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
SC 12-025

2. STATE
South Carolina

FOR: HEALTH CARE FINANCING ADMINISTRATION

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
November 1, 2012

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)

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42 CFR, Part 447

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a. FFY 2013 \$

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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. Keck was designated by the Governor
to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
December 18, 2012

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: 12/21/12

18. DATE APPROVED: 03/30/15

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
11/01/2012

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:
Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

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STATE OF SOUTH CAROLINA

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This plan establishes the methods and standards for reimbursement of outpatient hospital services effective November 1, 2012. Under this plan, a retrospective reimbursement system will be available for the following qualifying hospitals:

- Effective for services provided on or after November 1, 2012, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and Direct Medical Education (DME) costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will continue to receive ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.
- Effective for services provided on or after November 1, 2012, 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 will receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.
- Effective for services provided on or after November 1, 2012, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital, and DME costs. In order for a hospital to qualify under this scenario, a hospital must:
 - a. Be located in South Carolina or within 25 miles of the South Carolina border;
 - b. Have a current contract with the South Carolina Medicaid Program; and
 - c. Have at least 25 beds in its burn intensive care unit.

Determination of the Statewide Outpatient Hospital Fee Schedule Rates:

The October 1, 2007 statewide outpatient hospital fee schedule rates for acute care and long term acute care hospitals will be based upon

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the allowable outpatient cost information of covered services from each acute care hospital's FY 2005 cost report. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published on the agency's website. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims were used in this analysis. 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 cost. Outpatient allowable costs, charges and statistics will be extracted from the cost report and prepared for the rate computations using the following general guidelines. The FY 2005 SCDHHS Management and Administration Reporting System (MARS) paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

- As filed total facility costs are identified from each facility's FY 2005 Worksheet B Part I (BI) CMS-2552 cost report. Total outpatient facility costs would include operating, capital, and direct medical education. CRNA costs identified under BI, column 20 are removed from allowable costs. Observation cost is reclassified.
- As filed total facility costs will be allocated to Medicaid outpatient hospital cost using the following method:

A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges (as reported on Worksheet D Part V for Medicaid outpatient ancillary charges) to yield total SC Medicaid outpatient ancillary costs. The SC Medicaid outpatient 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 outpatient covered ancillary charges. The SC Medicaid outpatient cost-to-charge ratio will then be multiplied by the facility's SC Medicaid covered outpatient charges as identified on the SCDHHS MARS summary paid claims data report to determine each hospital's allowable SC Medicaid outpatient cost for FY 2005.

- The allowable Medicaid outpatient costs are summed to determine the aggregate Medicaid outpatient costs for FY 2005. An aggregate Medicaid allowable cost target was established at 95% of allowable Medicaid outpatient costs.
- After establishing the FY 2005 aggregate Medicaid allowable cost target, several actuarial models were developed and FY 2005 outpatient claims were repriced to determine the uniform increase in the statewide outpatient fee schedule rates. In order to trend the rates to the period October 1, 2007 through September 30, 2008, a 3.5% annual trend factor was applied. As a result of these steps, the statewide outpatient fee schedule rates increased by 135% effective October 1, 2007.

Determination of Hospital Specific Outpatient Multipliers:

In order to convert the statewide outpatient fee schedule rate payment into a hospital specific payment, an outpatient multiplier will be developed for each hospital. The outpatient multiplier will adjust the calculated statewide outpatient fee schedule claims payment to a hospital specific payment and will represent the projected outpatient costs calculated in accordance with Agency defined criteria effective November 1, 2012 and incorporate the impact of the July 11, 2011 payment reductions for the classes of hospitals outlined in this and the following three paragraphs. Hospitals that receive a hospital specific outpatient multiplier will be those eligible to receive retrospective cost settlements and those SC general acute care hospitals that no longer are eligible to receive retrospective cost settlements effective for services provided on or after November 1, 2012 as well as contracting out of state border hospitals that have S C Medicaid fee for service inpatient claims utilization of at least 200 claims.

Effective for services provided on or after November 1, 2012, all SC general acute care hospitals except those designated 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 and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 93% of allowable Medicaid targeted base costs less Direct Medical Education (DME)). Additionally, the hospital specific multipliers of the SC general acute care hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for the allowance of eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).

Effective for services provided on or after November 1, 2012, contracting out of state border hospitals that have SC Medicaid fee for service claim utilization of at least 200 claims will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 93% of allowable Medicaid targeted base costs less DME). Additionally, the hospital specific outpatient multipliers of the out of state border hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for DME costs (including the capital related costs) no longer being reimbursed to contracting out of state border hospitals.

Effective for services provided on or after November 1, 2012, all SC general acute care hospitals designated 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 and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 97% of allowable Medicaid targeted costs including DME).

Hospital Specific Outpatient Multiplier Calculation Effective 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) For all other hospitals that did not receive a hospital specific outpatient multiplier, an outpatient multiplier of .93 will be assigned to those hospitals.
- h) The hospital specific outpatient multiplier determined above (step f) will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability and coinsurance.

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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 total licensed beds of 90 or less 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 total licensed beds of 90 or less 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 November 1, 2012, 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. The cost to charge ratio will then be multiplied by 97% to take into account the April 8, 2011 payment reductions that apply to the hospitals that have been exempted from the July 11, 2011 payment reductions.
- 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.

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- The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable adjusted 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.

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.

Upper Payment Limits:

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 2012 2552-10 cost report serves as the base year cost report to be used for Medicaid rate setting and 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 that were determined using total cost from worksheet B Part I column 24 and total charges from worksheet C, column 8. 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 Global Insight 2010 CMS Hospital Prospective Reimbursement Market Basket Index First Quarter 2014 in order to trend the base year cost (HFY 2012) to the Medicaid rate period October 1, 2012 through September 30, 2013.
- (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, to account for the physical and occupational therapy rate changes since the base year, the Department reduced the base year outpatient hospital payments by 75% of the physical and occupational therapy payments received by the hospital during the base year. Next, the Department took the Medicaid outpatient hospital revenue as reflected in step (4) and reduced this amount by the impact of the June 1, 2012 PT and OT rate changes. Next, the Department divided the adjusted Medicaid outpatient hospital amount for each hospital by the October 1, 2011 hospital specific outpatient multiplier to arrive at the actual/adjusted Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year period.
- (6) Next, to account for the November 1, 2012 hospital specific outpatient multiplier update, the Department multiplied the November 1, 2012 hospital specific outpatient multipliers against the adjusted Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year (see step (5)). Because the hospital specific outpatient multiplier changed November 1, 2012, only 11 months of the annual projected November 1, 2012 estimated revenue is allowed. However, to account for projected October 2012 outpatient hospital revenue for hospitals eligible for retrospective cost settlement prior to November 1, 2012, the Department applied 1/12th of the Total Medicaid trended cost as determined in step (3) above and multiplied this amount by the applicable cost settlement percentage (i.e. 97%, 93%, or teaching hospital specific %) for each hospital. For hospitals that continue to receive retrospective cost settlements at 97% of allowable costs on and after November 1, 2012, the estimated revenue for the October 1, 2012 through September 30, 2013 payment period equals the trended inflated cost as described in step (3) multiplied by 97%. For hospitals that were not eligible to receive retrospective cost settlements prior to November 1, 2012, the October 1, 2012 through September 30, 2013 Medicaid revenue was estimated to equal the annual revenue based upon the application of the November 1, 2012 Medicaid outpatient multiplier against the adjusted statewide outpatient fee schedule payments (step 5).

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- (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 rate expenditures in step (6). In the event that aggregate Medicaid outpatient hospital rate expenditures 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).

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

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: