

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

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| TO <i>Myers</i> | DATE <i>10-15-07</i> |
|--------------------|-------------------------|


| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER <i>000203</i> | <input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR <i>cc: Wells, Ms. ForKner</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 |
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| 1. | | | |
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| 4. | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

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|--------------------|-------------------------|
| TO <i>Myers</i> | DATE <i>10-15-01</i> |
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| DIRECTOR'S USE ONLY | ACTION REQUESTED |
| 1. LOG NUMBER <i>000203</i> | <input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR <i>cc: Wells, Ms. Forkner</i>  | <input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ <input type="checkbox"/> FOIA DATE DUE _____ <input checked="" type="checkbox"/> Necessary Action |

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| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

October 10, 2007

Ms. Emma Forkner, Director
Department of Health and Human Services
P. O. Box 8206
Columbia, South Carolina 29202-8206

Log: Myers
c: WMS
Emma

RE: Partial Year Rate Decrease MCO Standard Contract (Wellpath) for 2007

Dear Ms. Forkner:

We have reviewed the proposed rate decrease for the period July 1, 2007 through December 31, 2007, for the Standard Model Medicaid MCO contract Wellpath of South Carolina, Inc. We found that the contract amendment, which includes the capitation rates that are within the rate range that was certified by an actuary, meets the requirements contained in 42 CFR 438 effective August 13, 2003. The rate range was approved on March 30, 2007. Based on our review of the submitted documents and information provided by your staff, we approve the rate decrease.

If any future actuarial study or financial review reveals inaccuracies in the submitted capitation rate cost data, we reserve the right to recover the federal share of any unallowable costs resulting from the inaccuracies. In addition, if errors in the rates are later determined, you will be required to adjust your quarterly expenditure report to the Centers for Medicare and Medicaid Services. We appreciate the effort and cooperation provided by your staff during our review. Should you have any questions, please contact Elaine Elmore at (404) 562-7408.

We appreciate the effort and cooperation provided by your staff during our review. Should you have any questions, please contact Elaine Elmore at 404-562-7408.

Sincerely,



Jay Gavens
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations