DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton/Chavis	11-19-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000117	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Director, Deps, Host, CMS file	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] 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

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

November 14, 2014

RECEIVED
NOV 18 2014
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. Anthony E. Keck
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 14-018

Dear Mr. Keck:

We have reviewed the proposed state plan amendment, SC 14-018, which was submitted to the Atlanta Regional Office on August 29, 2014. This state plan amendment will increase the minimum estate asset value upon which South Carolina can file claims from $10,000 to $25,000.

Based on the information provided, the Medicaid State Plan Amendment SC 14-018 was approved on November 14, 2014. The effective date of this amendment is October 1, 2014. We are enclosing the approved HCFA-179 and the plan page.

If you have any additional questions or need further assistance, please contact Maria Drake at (404) 562-3697 or Maria.Drake@cms.hhs.gov.

Sincerely,

Jackie Glaze

Jackie Glaze
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: 14-018

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, 2014

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:
42CFR433.36(c)1902(a)(18) and 1917(a) and (b) of The Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $ 0
b. FFY 2015 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.17-A, Page 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.17-A, Page 4

10. SUBJECT OF AMENDMENT:
To increase the minimum estate asset value upon which SCDHHS can file claims from $10,000 to $25,000.

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:
August 27, 2014

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
08/29/14

18. DATE APPROVED: 11/14/14

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/14

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

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

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

LIENS AND ADJUSTMENTS OR RECOVERIES

5. The State defines cost-effectiveness as follows (include methodology/thresholds used to determine cost-effectiveness):

If the value of the estate is determined (by receipt of affidavit) to be less than $25,000, the department will not file a claim. The assets of the estate must be $25,000 or more and the claims paid by Medicaid must be $500 or more. If the net assets of the estate are less than $4,000 after the payment of all priority expenses, then the department will withdraw its claim.

The State may settle its claim for a lesser amount if the State determines that it would be more cost effective and in the best interest of the State to do so than to continue to pursue collection of the full amount of the claim. Criteria to be considered in determining cost effectiveness may include the probability of collecting a larger amount, staff time, cost incurred, legal expense and length of time required to collect.

6. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

The application for Nursing Home or Community Base Waiver Services gives notification of the Estate Recovery Law. Upon the death of the recipient, a claims package is mailed to the Personal Representative of the recipient's estate. The package includes the following: Informational letter, creditor's claim, itemization of the claim, instruction for requesting /applying for a waiver, and copy of SC Estate Recovery Law. The letter states that the family has 45 days to request a waiver. Upon receipt of all of the requested information, the case analyst assigned to the case will render their decision within 15 days If the waiver is denied, Appeals procedures are mailed to the family certified allowing the family 30 days to request an Appeal.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Roberts/Taylor/FOIA	11-13-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000117	[ ] Prepare reply for the Director's signature DATE DUE
2. DATE SIGNED BY DIRECTOR cc: Brooks, Mullis Same as #15 Close	[ ] Prepare reply for appropriate signature DATE DUE [X] FOIA DATE DUE 11-28-14 [ ] 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.			

Capitol
Consultants, Inc.

RECEIVED
NOV 19 2014
Department of Health & Human Services
OFFICE OF THE DIRECTOR

November 6, 2014

Peter Brooks
Communications Director
South Carolina Department of Health & Human Services
1801 Main Street
Columbia, SC 29201

Via Email: peter.brooks@scdhhs.gov

Dear Mr. Brooks:

This letter is a request for access to the public records listed below pursuant to the S.C. Freedom of Information Act. I would like to review the following:

> Claims paid data for codes A0430, A0431, and A0435 for calendar years 2009, 2010, 2012, 2013 and the most recent 12 month period the state has available.

Please contact me at 803-252-1087 to schedule a time to examine the records.

If there is a charge for providing me access, please advise me of your estimate of the charge and the basis for the charge when you call to arrange an appointment.

Sincerely,

Annie W. Wilson
General Counsel

cc: Kim Cox

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at $10.00 per hour	_____ Hours	$_____
Pages copied at $.10 per page	_____ Pages	$_____
Pages faxed at $.20 per page	_____ Pages	$_____
Shipping and Handling Costs		$_____
Other costs associated with the FOIA request: _____		$_____
Total Amount Due SCDHHS:		**$_____**

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact _____ should you have any questions.

_____ _____
Signature Date: