

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

SRA SC-09-400

TO	DATE
Mells	3-15-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100388	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Ms. Forkner, Deps, CUS file	<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
7500 Security Boulevard, Mail Stop 52-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations (CM50)

Ms. Emma Forkner
Director

MAR 15 2010

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

RECEIVED

MAR 15 2010

RE: SPA SC 09-012

Department of Health & Human Services
OFFICE OF THE DIRECTOR


Dear Ms. Forkner:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-012. Effective October 1, 2009, this amendment modifies the State's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, the amendment will update the base year cost reports used to determine DSH eligibility and DSH payments, update the market basket index used to increase provider rates, and increase hospital payment rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 1, 2009. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332 or Vanesa Day at 410-786-8281.

Sincerely


a. Cindy Mann
Director, CM50

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0918-0193TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL1. TRANSMITTAL NUMBER:
SC 09-0122. 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

4. PROPOSED EFFECTIVE DATE
October 1, 2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

6. COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

7. FEDERAL BUDGET IMPACT:

a. FFY 2010 \$46.4 Million
b. FFY 2011 Rates + DSH will be updated9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 4, 7, 11, 13, 16, 17, 18, 24, 27 through 28a
and 32Attachment 4.19-A, pages 4, 7, 11, 13, 16, 17, 18, 24, 27 through
28a and 32

10. SUBJECT OF AMENDMENT:

Effective October 1, 2009, annual updates to: (1) October 1, 2009 inpatient rates/multipliers; (2) FFY 2010 DSH Allotment; (3) Base Year
Cost/Data Reports used for FY 2010 DSH; and (4) update to cost components for each hospital's specific DSH limit.

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:Ms. Forkner was designated by the
Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Emma Forkner

16. RETURN TO:

13. TYPED NAME:
Emma ForknerSouth Carolina Department of Health and Human Services
Post Office Box #206
Columbia, SC 29202-820614. TITLE:
Director15. DATE SUBMITTED:
December 18, 2009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

3-15-10

19. EFFECTIVE DATE OF APPROVED MATERIAL:
PLAN APPROVED - ONE COPY ATTACHED

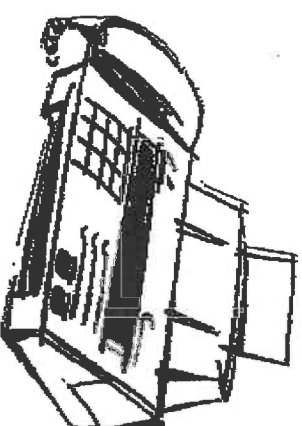
20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

John P. Forkner

22. TITLE:

23. REMARKS:



U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Finance, Systems and Budget Group (FSBG)
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244
Fax # 410-786-1008

Fax Cover Sheet

Date: March 15, 2010

From: Mark Costello

Phone: _____

Stacey Githens
Finance, Systems and Budget Group
Survey and Administration Budget Staff
Division of Reimbursement & State Financing
Division of Financial Management
Division of State Systems
Division of Information Analysis & Technical Assistance
Division of National Systems
DATA Analysis Team

To: Ann Jordan Director

Organization: Dept of Health & Human Services

Phone: _____

Fax: 803-898-4515

Number of pages (including cover sheet): 3

Remarks: TM 03-12

Approved letter

179 form

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CMS FAX FORM