

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

| | |
|--------------------|------------------------|
| TO <i>Wells</i> | DATE <i>1-31-08</i> |
|--------------------|------------------------|


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|--|---|
| DIRECTOR'S USE ONLY | ACTION REQUESTED |
| 1. LOG NUMBER <i>000402</i> | <input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR <i>cc: Ms. Forkner, Daps</i> <i>g</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 AND HUMAN SERVICES
OFFICE OF DIRECTOR

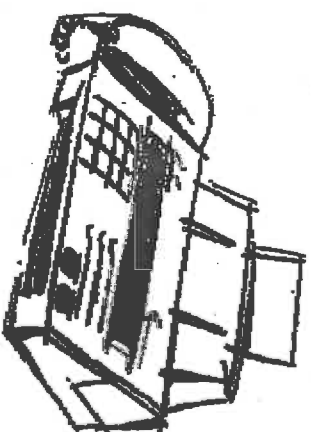
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U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Finance, Systems and Budget Group (FSBG)
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244
Fax # 410-786-1008



Fax Cover Sheet

RECEIVED

JAN 31 2008

Date: Jan 31, 2008
From: Must lobby for
State Justice

Phone: _____
Department of Health & Human Services
OFFICE OF THE DIRECTOR

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: Anna Parker, Director

Organization: Dept. of Health & Human Serv.

Phone: _____

Fax: 803-898-4515

Number of pages (including cover sheet): 3

Remarks: TN 07-07

Approved letter & 176 form

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CMS FAX FORM

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

Ms. Emma Forkner
Director

JAN 30 2008

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

Dear Ms. Forkner:

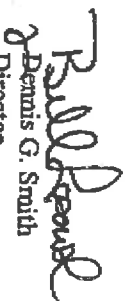
We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 07-007. This amendment modifies the State's payment methodology for setting payment rates for nursing home services. Effective October 1, 2007 this amendment revises the base year cost reports to be used to determine the per diem rates and provides for an inflation increase, incorporates the Medicare guidelines for determination of allowable cost of professional liability claims, and increases rates for the cost of Certified Nurse Aides providing escort services while recipients are being provided non-emergency transportation services to a medical provider for covered services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(e) 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, 2007. We are enclosing the CMS-179 and the amended approved plan pages.

Under regulations at 42 CFR 430.12(c)(i), States are required to amend State plans whenever necessary to implement changes in Federal law, regulations, policy interpretations, or court decisions. On May 25, 2007, CMS placed a final rule, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) on display at the Federal Register and that can be found at 72 Fed. Reg. 29748 (May 29, 2007) that would modify Medicaid reimbursement. Because of this regulation, some or all of the payments under this plan amendment may no longer be allowable expenditures for federal Medicaid matching funds. Public Law 110-28, enacted on May 25, 2007 instructed CMS to take no action to implement this final regulation for one year. CMS will abide by the time frames specified by the statute. Approval of the subject State plan amendment does not relieve the State of its responsibility to comply with changes in federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements.

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

Sincerely,


Dennis G. Smith
Director

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| DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION | | REVISED 01-23-08 FORM APPROVED OMB NO. 0938-0193 | |
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | | |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | 1. TRANSMITTAL NUMBER: SC 07-007 | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 2. STATE South Carolina | |
| 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | | 4. PROPOSED EFFECTIVE DATE October 1, 2007 | |
| 5. TYPE OF PLAN MATERIAL (Check One): | | | |
| <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR, Subpart C | | 7. FEDERAL BUDGET IMPACT: \$23,300,000 x 69.79% a. FFY 2007 \$16,261,070 b. FFY 2008 Rates will be rebased. | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Pages 2, 6, 7, 8 and 14 thru 41 | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if Applicable): Attachment 4.19-D, Pages 2, 6, 7, 8 and 14 thru 35 | |
| 10. SUBJECT OF AMENDMENT: Nursing Facility rate update effective October 1, 2007 based upon annual rebasing. | | | |
| 11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Emma Fortner</i> | | 16. RETURN TO: South Carolina Department of Health and Human Services Post Office Box 8206 Columbia, SC 29202-8206 | |
| 13. TYPED NAME: Emma Fortner | | | |
| 14. TITLE: Director | | | |
| 15. DATE SUBMITTED: November 7, 2007 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: | | 18. DATE APPROVED: 1-30-08 | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: PLAN APPROVED - ONE COPY ATTACHED | | 20. SIGNATURE OF REGIONAL OFFICIAL: <i>John D. S.</i> | |
| 21. TYPED NAME: | | 22. TITLE: | |
| 23. REMARKS: | | | |