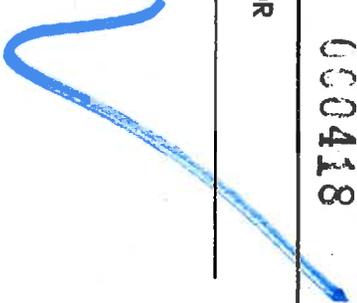


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

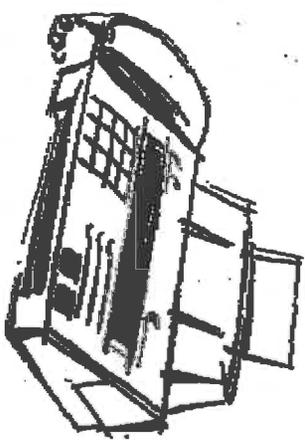
ACTION REFERRAL

TO	DATE
Mells	12-20-06

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000418	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Bowling 	<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.			

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

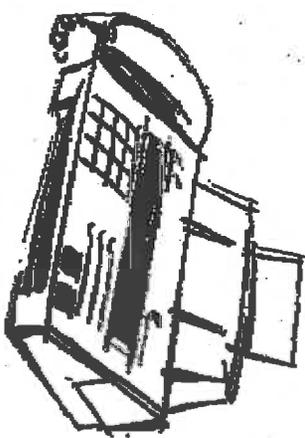


**RECEIVED**

DEC 20 2006

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

*log: Wells*  
*c: Bowling*  
*NA*



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

Date: Dec 19, 2006

DEC 20 2006

From: Mark Goff for  
Vernor Spivack

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: Robert Kerr Director

Organization: Dept. of Health & Human Services

Phone: \_\_\_\_\_  
Fax: 803-898-4575

Number of pages (including cover sheet): 3

Remarks: TN 06-13  
Approval Letter + 170 form

Note: The information following this cover sheet and attached in this transmittal is confidential. It is intended for the sole use of the person(s) to whom it is addressed. If the reader of this message is not the named addressee (or an employee or agent responsible for delivering this message to the intended recipient(s)), please do not read the accompanying information. The dissemination, distribution, or copying of this communication by anyone other than the addressee is strictly prohibited. Anyone receiving this message in error should notify us immediately by telephone and return the original of the transmission to us at the above address by U.S. Mail. Thank you for your cooperation.

CMAS FAX FORM

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

Mr. Robert M. Kerr

Director

Department of Health and Human Services

P.O. Box 8206

Columbia, South Carolina 29202-8206

DEC 19 2006

RECEIVED

DEC 20 2006

RE: South Carolina 06-013

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Dear Mr. Kerr:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 06-013. This amendment modifies the State's payment methodology for setting payment rates for nursing facility services. Specifically, this amendment incorporates the adjustments made to the State's nursing facility rate setting methodology and allowable cost definitions based on the annual rebasing of rates effective on or after October 1, 2006.

We conducted our review of your submittal according to Medicaid statutory requirements in sections 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and implementing Federal regulations at 42 CFR Part 447. I am pleased to inform you that South Carolina State plan amendment 06-013 is approved effective October 1, 2006.

If you have any questions related to this letter, please call Venessa Johnson at (410)-786-8281.

Sincerely,

*Dennis G. Smith*

Dennis G. Smith  
Director

09/27/2006 09:35 603-698-4515

HEALTH & HUMAN SERV.

PAGE 18/44

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED  
OMB NO. 0938-0199

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

1. TRANSMITTAL NUMBER:  
SC 06-013

2. STATE  
South Carolina

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XDX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR

4. PROPOSED EFFECTIVE DATE  
October 1, 2006

HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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, Subpart C

7. FEDERAL BUDGET IMPACT: \$25,000 x 69.54%

a. FY 2007  
b. FY 2008

\$17,385  
Rates will be reduced.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Attachment 4.19-D, Pages 1, 2, 6, 8, 13 thru 17, 19, 26, 29, 30, 32, and 34

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):  
Attachment 4.19-D, Pages 1, 2, 6, 8, 13 thru 17, 19, 26, 29, 30, 32, and 34

10. SUBJECT OF AMENDMENT:

Netting Facility rate update effective October 1, 2006 based upon annual rebasing.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

*Robert M. Kaar*

13. TYPED NAME:  
Robert M. Kaar

16. RETURN TO:  
South Carolina Department of Health and Human Services  
Post Office Box 8206  
Columbia, SC 29202-8206

14. TITLE:  
Director

15. DATE SUBMITTED:  
September 27, 2006

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: