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: SC 08-024

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, 2008

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:

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 ($2,300,000)
b. FFY 2010 ($2,300,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Limitation Supplement, Page 7a
Attachment 4.19-B, Page 6.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, Limitation Supplement, Page 7a
Attachment 4.19-B, Page 6.2

10. SUBJECT OF AMENDMENT:
Update the nursing facility room and board rate for residents receiving hospice services, reducing it from 100% to 98% of the facilities' Medicaid room and board rate. Room and board rates will be unchanged for residents not receiving hospice services.

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:

13. TYPED NAME: Emma Forkner

14. TITLE: Director

15. DATE SUBMITTED: September 29, 2008

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/30/08

18. DATE APPROVED: 07/26/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/08

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

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

23. REMARKS:

Approved with following changes as authorized by State Agency on email and letter dated 07/22/10

Block #7a Changed to read: FFY 2009 (576,923); **Block 7b Changed to read**: FFY 2010 (576,923)**Block # 8 Changed to read**: Attachment 3.1-A, Page 9; Attachment 3.1-A, Limitation Supplement, Pages 4a, 4b, 6d, 6e and 10a; Attachment 4.19-B, Pages 3, 3.1, 6.2 and 6h.5. **Block # 9 Changed to read**: Attachment 3.1-A, page 9; Attachment 3.1-A, Limitation Supplement , pages 4a, 4b, 6d, 6e and 10a and Attachment 4.19-B, Pages 3, 6.2 and 6h.5