DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton/Chavis	4-4-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER -- 000305	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: COS, Dr. Keck, Deps, CLS 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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 20, 2013

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 12-021

Dear Mr. Keck:

We have reviewed the proposed State Plan Amendment, SC 12-021, which was submitted to the Atlanta Regional Office on December 28, 2012. This amendment changes the language under the managed care excluded services for institutional long term care facilities/nursing from after the first thirty (30) continuous days post admission to after the first ninety (90) continuous days post admission. Additionally, the amendment removes the language "Alcohol and Other Drug Abuse Treatment Services" and replaces the language with "Mental Health Services authorized or provided by State Agencies."

Based on the information provided, the Medicaid State Plan Amendment SC 12-021 was approved on March 20, 2013. The effective date of this amendment is October 1, 2012. We are enclosing the approved HCFA-179 and the plan pages.

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: SC 12-021

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, 2012

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:
The Social Security Act §1932(a)(5)(D)
§1905(t)

7. FEDERAL BUDGET IMPACT: (0)
a. FFY 13 $0 Shift of dollars from FFS to MCO Cap rate
b. FFY 14 $0 Shift of dollars from FFS to MCO Cap rate

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Page 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, Page 13

10. SUBJECT OF AMENDMENT:
Managed Care Excluded 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:
Mr. Keck was designated by the Governor to review and approval all state plans.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
December 20, 2012

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/28/12

18. DATE APPROVED: 03-20-13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/12

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:

Citation	Condition or Requirement

√ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

The State does not use any additional circumstances of "cause" for disenrollment other than those detailed in 42 CFR 438.56(c).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

√ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

PCCM excluded services: None
MCO excluded services:

Institutional Long Term Care Facilities/Nursing (after the first ninety (90) continuous days post- admission)
Mental Health Services authorized or provided by State Agencies
Non-Ambulance Transportation
Glasses, contacts and fitting fees
Dental Services
Targeted Case Management Services
Pregnancy Prevention Services – Targeted Populations
MAPPS Family Planning Services
Organ Transplantation
School Based Services

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will__/will not √_____ intentionally limit the number of entities it contracts under a 1932 state plan option.