


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

**ACTION REFERRAL**

TO <i>Wells</i>	DATE <i>12-29-08</i>
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<b>DIRECTOR'S USE ONLY</b>	<b>ACTION REQUESTED</b>
1. LOG NUMBER  <i>100345</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR  	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

<b>APPROVALS</b> (Only when prepared for director's signature)	<b>APPROVE</b>	<b>* DISAPPROVE</b> (Note reason for disapproval and return to preparer.)	<b>COMMENT</b>
1.			
2.			
3.			
4.			

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
61 Forsyth St, Suite 4120  
Atlanta, Georgia 30303-8909

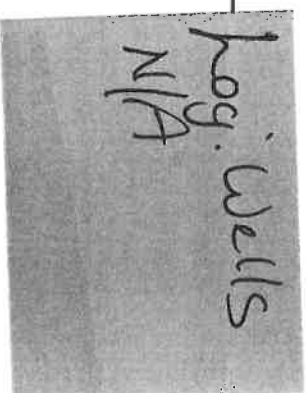


**RECEIVED**

December 5, 2008

DEC 29 2008

Department of Health & Human Services  
OFFICE OF THE DIRECTOR



Ms. Emma Forkner, Director  
South Carolina Department of Health and Human Services  
Post Office Box 8206  
Columbia, South Carolina 29202-8206

Re: South Carolina Title XIX State Plan Amendment, Transmittal #08-010

Dear Ms. Forkner:

We accept your request, dated December 3, 2008, to withdraw the above State Plan Amendments. We are returning all Form HCFA-179s and the proposed plan pages.

If you have any questions regarding this amendment, please contact Elaine Elmore at (404) 562-7408.

Sincerely,

Mary Kaye Justis, RN, MBA  
Acting Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

Enclosures

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

1. TRANSMITTAL NUMBER:  
SC 08-010

2. STATE  
South Carolina

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

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

TO: REGIONAL ADMINISTRATOR

4. PROPOSED EFFECTIVE DATE  
April 1, 2008

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:

7. FEDERAL BUDGET IMPACT:

a. FFY 2008 \$41,076  
b. FFY 2009 \$82,152

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):

Attachment 3.1-A, Limitation Supplement, Pages 8t – 8w

Attachment 3.1-A, Limitation Supplement, Pages 8t – 8w

10. SUBJECT OF AMENDMENT:

Targeted Case Management for sickle cell **di** **sease**.

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:

16. RETURN TO:

13. TYPED NAME:

Emma Forkner

SC Department of Health and Human Services  
Post Office Box 8206

14. TITLE:

Director

Columbia, South Carolina 29202-8206

15. DATE SUBMITTED:

June 30, 2008

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED:

19. EFFECTIVE DATE OF APPROVED MATERIAL:

PLAN APPROVED – ONE COPY ATTACHED

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

**Target Group: Sickie Cell Disease**

Coverage is limited to non-institutionalized Medicaid individuals diagnosed by laboratory testing as having sickle cell disease or must preliminary laboratory tests showing evidence of sickle cell disease. If further laboratory testing shows that the individual does not have sickle cell disease, he or she will no longer be eligible for sickle cell services.

*For case management services provided to individuals in medical institutions, select one of the following:*

X Target group is comprised of individuals transitioning to a community setting during the last 60 consecutive days of a covered, long-term stay, in a medical institution, that is 180 consecutive days or longer in duration.

X Target group is comprised of individuals transitioning to a community setting during the last 14 consecutive days of a covered, short-term stay, in a medical institution, of less than 180 consecutive days in duration.

Areas of state in which services will be provided:

X Entire State

     Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

     Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope.

Definition of services: Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history;
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

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Effective Date: 04/01/08

RO APPROVAL:

SUPERSEDES: MA 94-009

Attachment 3.1-A

Limitation Supplement

Page 8u

- identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with
  - medical, social, educational providers or
  - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

*For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community:* Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities.

Qualifications of Providers:

Providers of case management may be any public or private entity, including, but not restricted to, local health departments, community health clinics, rural health centers and non-profit sickle cell organizations regardless of whether they provide other Medicaid services. Case management providers may qualify for enrollment upon demonstration of the ability to provide case management services in accordance with the requirements set forth by Medicaid and by signing an agreement with the State Department of Health and Human Services as a case manager provider for sickle cell disease.

The case manager shall be a Registered Nurse (R.N.) and/or a Social Worker. The R.N. must be licensed in South Carolina and have either: a) a minimum of one year adult medical/surgical clinical experience plus either an additional six months experience in pediatrics, or have taken a pediatric assessment course in the last six months, or; b) have the minimum of one year pediatric experience plus either an additional six months experience in adult medical/surgical experience or have taken an adult assessment course in the

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 Effective Date: 04/01/08  
 RO APPROVAL:  
 SUPERSEDES: MA 98-006

last six months. The nurse should also attend, at least one in-service training related to sickle cell disease approved by DHHS annually.

The Social Worker must either have: Master of Social Work Degree or Bachelor of Social Work Degree, licensed as LMSW, LISW or LBSW by the South Carolina Board of Social Work Examiners. The LBSW must be under the supervision of a master's level social worker (LMSW, LISW). A social worker must have at least one year's experience working with individuals in a health/human service environment and must attend at least one in-service training related to sickle cell disease approved by DHHS annually.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:

The State assures that case management services will not be used to restrict an individual's access to other services under the plan.

The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

The State assures that individuals will receive comprehensive, case management services, on a one-to-one basis, through one case manager.

The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

*[For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community, the State makes the following assurances:]*

The State assures that the amount, duration, and scope of the case management activities would be documented in an individual's plan of care which includes

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SUPERSEDES: MA 94-010

case management activities prior to and post-discharge, to facilitate a successful transition to the community.

The State assures that case management is only provided by and reimbursed to community case management providers.

The State assures that Federal Financial Participation is only available to community providers and will not be claimed on behalf of an individual until discharge from the medical institution and enrollment in community services.

Case Records:

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid on a unit-of-service basis that does not exceed 15 minutes. A detailed description of the reimbursement methodology identifying the data used to develop the rate, is included in Attachment 4.19B.

Limitations:

Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
- Activities integral to the administration of foster care programs;
- Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act;
- Case management activities to clients participating in any waiver program that includes case management services.

SC 08-010  
Effective Date: 04/01/08  
RO APPROVAL:  
SUPERSEDES: MA 98-006

**Holly, Mary V. (CMS/CMCHO)**

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**From:** CMS SPA Waivers Atlanta\_R04  
**Sent:** Monday, June 30, 2008 1:45 PM  
**To:** Holly, Mary V. (CMS/CMCHO); Noonan, Darlene F. (CMS/SC)  
**Subject:** FW: SPA SC 08-010

**Attachments:** SC 08-010TCM SPA- final 62708.doc; CMS179 signed SC 08-010Coversheet.pdf; LTR-CMS signed & datedSC 08-010.pdf



SC 08-010TCM CMS179 signed LTR-CMS  
7A- final 62708: 08-010Covershd & datedSC 08

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From: Elizabeth Hutto[SMTP:HUTTOE@SCDHHS.GOV]  
Sent: Monday, June 30, 2008 1:44:24 PM  
To: CMS SPA Waivers Atlanta R04  
Cc: Noonan, Darlene F. (CMS/SC); Elmore, Elaine (CMS/SC); Holly, Mary V. (CMS/CMCHO); Pheobia Cooper; Rick Hepfer; Deirdra Singleton; Sam walddrep  
Subject: SPA SC 08-010  
Auto forwarded by a Rule

Attached are the attachments for SC 08-010. This plan amendment is for the targeted case management for Sickle Cell Disease.

If additional information is needed, please let me know. Thanks!

Elizabeth F. Hutto  
Finance and Administration  
SC Department of Health and Human Services PO Box 8206 Columbia, SC 29202-8206  
(803) 898-2503  
Fax (803) 255-8235  
Huttoe@scdhhs.gov

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