Table of Contents

State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 13-006

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

January 27, 2014

Mr. Anthony E. Keck
Director
South Carolina 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 13-006

Dear Mr. Keck:

We have reviewed the proposed State Plan Amendment, SC 13-006, which was submitted to the Atlanta Regional Office on November 8, 2013. This amendment allow dual eligible (Medicare/Medicaid) beneficiaries to voluntarily enroll in managed care; revise state plan language to have beneficiaries under one (1) year of age enroll in a health plan and revise state plan language to reflect SCDHHS will perform the face to face informed choice counseling with beneficiaries who are selecting a managed care option.

Based on the information provided, the Medicaid State Plan Amendment SC 13-006 was approved on January 27, 2014. The effective date of this amendment is October 1, 2013. 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,

//s//

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 13-006

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, 2013

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:
1932(a)(2)(B) 42 CFR 438(d)(1)
42 CFR 438.50
1932(a)(4) 42 CFR 438.50

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $0
b. FFY 2014 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, pages 5, 9 & 10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, pages 5, 9, & 10

10. SUBJECT OF AMENDMENT: This State Plan changes the following: removes check mark in State Plan allowing dual eligible (Medicaid/Medicare) beneficiaries to voluntarily enroll into Managed Care; revises State Plan language to make beneficiaries under one (1) year of age, where SCDHHS cannot determine the mother's enrollment in a health plan, a mandatory managed care eligible group; and revises State Plan language to reflect current language in the scope of service for the Request For Proposal (RFP) which states SCDHHS will perform the face to face informed choice counseling with beneficiaries who are selecting a managed care option.

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 approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Anthony E. Keck

14. TITLE: Director

15. DATE SUBMITTED: November 8, 2013

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 11/08/13	**18. DATE APPROVED: 01/27/14**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/13	**20. SIGNATURE OF REGIONAL OFFICIAL:** //s//
21. TYPED NAME: Jackie Glaze	**22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns**

23. REMARKS:

FORM HCFA-179 (07-92)

Citation	Condition or Requirement
	ix. Aged or disabled beneficiaries (ABD) who have countable monthly income at or below 100% of the Federal Poverty level and resources below a defined limit. x. Working Disabled beneficiaries who meet the Social Security definition of disabled and are working who also meet financial criteria. xi. Beneficiaries who are uninsured women diagnosed and found to need treatment for breast and/or cervical cancer or pre-cancerous lesions.
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i._____Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. √_____Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. Tribal members are identified by Indian Health Service providers and associated claims are paid under the fee-for-service system.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii.√___Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.√___Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

Citation	Condition or Requirement
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment The following eligible groups will be excluded from enrolling in managed care: 1. Beneficiaries in a nursing home or institutional long-term care facility. 2. Beneficiaries hospitalized for an extended period longer than thirty (30) days. 3. Beneficiaries receiving family planning services only. 4. Beneficiaries that are considered refugees.
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis Other eligible groups that will be excluded from mandatory enrollment into managed care but may enroll on a voluntary basis include the following categories of beneficiaries: 1. Beneficiaries in home and community waiver programs. 2. Beneficiaries who reside in a residential care facility or a community long-term care facility.
	H. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve:

Citation	Condition or Requirement

i. the existing provider-recipient relationship (as defined in H.1.i).

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

The State utilizes an Enrollment Broker to provide enrollment assistance in an unbiased, informative manner. The Enrollment Broker assists the beneficiary's plan selection by matching the Plan's providers, services and locations with the beneficiary's needs and preferences by discussing participating providers and special services offered by the various plans. The Enrollment Package that is issued to each eligible beneficiary provides directions that enable them to make an informed choice regarding their managed care plan and provider; preserving the beneficiary's current provider relationship if desired. The SCDHHS offers each beneficiary, including non-English speaking beneficiaries, an opportunity to personally visit with an Enrollment Counselor within regions, or by appointment in each county, to complete the Enrollment process or provide other assistance. The Enrollment Broker also provides training opportunities to the provider community that emphasizes the opportunities managed care offers to their patients. Educational campaigns emphasizing the benefits of a medical home are also directed to the beneficiaries. When qualified beneficiaries fail to select a managed care health plan, the Enrollment Broker will assign them to a plan. The assignment of beneficiaries to a health plan incorporates algorithms that ensure an equitable distribution of beneficiaries to each plan eligible to receive new members. The assignment process includes logic that assures the beneficiary of a secondary choice, should the assigned plan not meet their needs.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will √/will not ___ use a lock-in for managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days