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State/Territory Name: South Carolina

State Plan Amendment (SPA) #:13-0026-MM7

This file contains the following documents in the order listed:

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

December 17, 2015

Mr. Christian Soura
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 13-0026-MM7

Dear Mr. Soura:

Enclosed is an approved copy of South Carolina's state plan amendment (SPA) 13-0026-MM7, which was originally submitted to the Centers for Medicare & Medicaid Services (CMS) on December 31, 2013. SPA 13-0026-MM7 establishes that one or more qualified hospitals are determining presumptive eligibility, and that the state is providing coverage for individuals determined presumptively eligible, in accordance with the Affordable Care Act. The SPA was approved on December 17, 2015. The effective date of this SPA is January 1, 2014.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the back of South Carolina's approved state plan.

If you have any questions, please contact Maria Drake at 404-562-3697.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **South Carolina**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

SC-13-0026

Proposed Effective Date

01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435.1110

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

S21 Presumptive Eligibility by Hospitals

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  Mr. Anthony Keck, Agency Director, was designated by the South Carolina Governor to review and approve all State Plans.

Signature of State Agency Official

Submitted By:	**Sheila Chavis**
Last Revision Date:	**Dec 15, 2015**
Submit Date:	**Dec 31, 2013**

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals **S21**

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

☑ A qualified hospital is a hospital that:

☑ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

☑ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(•) Yes ( ) No

☑ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

- ☑ Pregnant Women
- ☑ Infants and Children under Age 19
- ☑ Parents and Other Caretaker Relatives
- ☑ Adult Group, if covered by the state
- ☑ Individuals above 133% FPL under Age 65, if covered by the state
- ☑ Individuals Eligible for Family Planning Services, if covered by the state
- ☑ Former Foster Care Children
- ☑ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state
- ☐ Other Family/Adult groups:
- ☐ Eligibility groups for individuals age 65 and over
- ☐ Eligibility groups for individuals who are blind
- ☐ Eligibility groups for individuals with disabilities
- ☐ Other Medicaid state plan eligibility groups
- ☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Medicaid Eligibility

(•) Yes ( ) No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards: SCDHHS will require that 90% of individuals determined presumptively eligible submit a regular application before the end of the presumptive eligibility period.

☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards: SCDHHS will require that 90% of individuals who submit an application before the end of the presumptive eligibility period are determined eligible for Medicaid.

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

( ) No more than one period within a calendar year.

(•) No more than one period within two calendar years.

( ) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

(•) Yes ( ) No

( ) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

(•) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

Medicaid Eligibility

- [x] The presumptive eligibility determination is based on the following factors:
  - [x] The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)
  - [x] Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.
  - [x] State residency
  - [x] Citizenship, status as a national, or satisfactory immigration status
- [x] The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Healthy Connections

South Carolina Department of Health and Human Services

Medicaid Presumptive Eligibility

PRIORITY PROCESSING
This is not a full Medicaid application

things to know

Who is authorized to complete this application?

- Hospitals have the option to perform Presumptive Eligibility (PE) determinations for select Medicaid coverage as granted by the Affordable Care Act.
- An employee of an authorized hospital may use this application to conduct an eligibility determination on a potentially Medicaid-eligible applicant. Only those employees who have been trained by Healthy Connections are allowed to conduct an eligibility determination.
- To participate in the PE program, hospitals must (i) participate in Medicaid and (ii) not be disqualified. Presumptive eligibility determinations must be performed by a hospital employee, and authority may not be delegated to any non-employee, including employees of affiliated entities.

Who is eligible for this program?

An individual receiving hospital services or community member who does not have insurance coverage, but who, based on their self-reported income and circumstances, may be eligible for Medicaid coverage.

Presumptive Eligibility may only be applied to the following Medicaid categories:

- Children under Age 19 (PHC)
- Parents and Caretaker Relatives (PCR)
- Former Foster Care (FFC) Children to Age 26
- Breast and Cervical Cancer Treatment Program (BCCP)
- Healthy Connections Checkup*
- Pregnant Women (PW) **

* *Checkup category does not provide full Medicaid benefits.*
** *PW is limited to ambulatory prenatal care and does not include labor and delivery.*

Where can I find resources to help complete this application?

- Visit scdhhs.gov and read our Frequently Asked Questions.
- Call the Provider Service Center at (888) 289-0709 to speak to a representative.
- Check out this online resource: http://medicaidelearning.com.

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 1: PERSON 1 Tell us about the individual.

PRESUMPTIVE ELIGIBILITY

All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix	Relationship to PERSON 1 SELF

2. Date of birth (mm/dd/yyyy)	3. Sex: ☐ Male ☐ Female

4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number

6. City	7. State	8. ZIP code	9. County

10. Mailing address (if different from home address)	11. Apartment or suite number

12. City	13. State	14. ZIP code	15. County

16. Phone number (Leave blank if you don't have one.) ( )	17. E-mail address (Leave blank if you don't have one)

18. Does the applicant need health coverage? If "No", go to question 26. ☐ Yes ☐ No

19. Is the applicant a resident of South Carolina? ☐ Yes ☐ No

20. Is the applicant a US citizen or US national? ☐ Yes ☐ No

a. If no, is the applicant a qualified alien? ☐ Yes ☐ No

21. Social Security Number (Optional): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

22. Is the applicant pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

23. Is this person a parent or caretaker relative? ☐ Yes ☐ No

24. Has the applicant been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

25. Was the applicant enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

26. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount $ _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount $ _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 1: PERSON 2

Tell us about the individual's family. PRESUMPTIVE ELIGIBILITY

Include the individual's family members who live with the individual, including the individual's spouse/partner and children under 19. If the applicant is under 19, include the applicant's spouse/partner, children, parents and siblings. All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix	Relationship to PERSON 1

2. Date of birth (mm/dd/yyyy)	3. Sex: ☐ Male ☐ Female

4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number

6. City	7. State	8. ZIP code	9. County

10. Mailing address (if different from home address)	11. Apartment or suite number

12. City	13. State	14. ZIP code	15. County

16. Phone number (Leave blank if you don't have one.)	17. E-mail address (Leave blank if you don't have one.)

18. Does this person need health coverage? If "No", go to question 26. ☐ Yes ☐ No

19. Is this person a resident of South Carolina? ☐ Yes ☐ No

20. Is this person a US citizen or US national? ☐ Yes ☐ No

a. If no, is this person a qualified alien? ☐ Yes ☐ No

21. Social Security Number (Optional): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

22. Is the person pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

23. Is this person a parent or caretaker relative? ☐ Yes ☐ No

24. Has this person been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

25. Was this person enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

26. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount $ _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount $ _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 1: PERSON 3

Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include the individual's family members who live with the individual, including the individual's spouse/partner and children under 19. If the applicant is under 19, include the applicant's spouse/partner, children, parents and siblings. All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix	Relationship to PERSON 1

2. Date of birth (mm/dd/yyyy)	3. Sex: ☐ Male ☐ Female

4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number

6. City	7. State	8. ZIP code	9. County

10. Mailing address (if different from home address)	11. Apartment or suite number

12. City	13. State	14. ZIP code	15. County

16. Phone number (Leave blank if you don't have one.)	17. E-mail address (Leave blank if you don't have one.)

18. Does this person need health coverage? If "No", go to question 26. ☐ Yes ☐ No

19. Is this person a resident of South Carolina? ☐ Yes ☐ No

20. Is this person a US citizen or US national? ☐ Yes ☐ No

a. If no, is this person a qualified alien? ☐ Yes ☐ No

21. Social Security Number (Optional): ___ ___ ___ - ___ ___ -___ ___ ___ ___

22. Is the person pregnant? ☐ Yes ☐ **No**

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

23. Is this person a parent or caretaker relative? ☐ Yes ☐ No

24. Has this person been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

25. Was this person enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

26. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount $ _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount $ _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 1: PERSON 4

Tell us about the individual's family. PRESUMPTIVE ELIGIBILITY

Include the individual's family members who live with the individual, including the individual's spouse/partner and children under 19. If the applicant is under 19, include the applicant's spouse/partner, children, parents and siblings. All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix	Relationship to PERSON 1

2. Date of birth (mm/dd/yyyy)	3. Sex: ☐ Male ☐ Female

4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number

6. City	7. State	8. ZIP code	9. County

10. Mailing address (if different from home address)	11. Apartment or suite number

12. City	13. State	14. ZIP code	15. County

16. Phone number (Leave blank if you don't have one.)	17. E-mail address (Leave blank if you don't have one.)

18. Does this person need health coverage? If "No", go to question 26. ☐ Yes ☐ No

19. Is this person a resident of South Carolina? ☐ Yes ☐ No

20. Is this person a US citizen or US national? ☐ Yes ☐ No

a. If no, is this person a qualified alien? ☐ Yes ☐ No

21. Social Security Number (Optional): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

22. Is the person pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

23. Is this person a parent or caretaker relative? ☐ Yes ☐ No

24. Has this person been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

25. Was this person enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

26. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount $ _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount $ _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

If you have more people to add, complete this form for each additional person.

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 2 Sign this application

PRESUMPTIVE ELIGIBILITY

▶ Signature of applicant/individual listed in Step 1 (Optional)	Date (mm/dd/yyyy)

STEP 3 Return the completed application.

PRESUMPTIVE ELIGIBILITY

Mail your signed application to:

SCDHHS
PO Box 100101
Columbia SC 29202-3101

–OR–

Fax your signed application to:

(803) 255-8253

If you want to register to vote, you can complete a voter registration form at scvotes.org.