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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:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages
- 4) Additional Attachments that are part of the state plan

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

te/Territory name: insmittal Number:	South Carolina
Please enter the Transmittal Numb	T(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 numb SC-13-0026	with leading zeros. The dashes must also be entered.
30-13-0020	
posed Effective Date 01/01/2014 (m	
01/01/2014 (mi	(dd/yyyy)
laugh Statute / Degulation Citati	
leral Statute/Regulation Citati 42 CFR 435.1110	n
42 01 (455.1110	
loral Budgot Impact	
leral Budget Impact Federal Fiso	l Year Amount
First Year 2014	\$0.00
Second Year 2015	\$0.00
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Medicaid Eligibility

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

Presumptive Eligibility by Hospitals S21					
42 CFF	R 435.1110				
	more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid ge for individuals determined presumptively eligible under this provision.				
• Yes	C No				
7 The	e 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				
	B 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.				

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(*)	Yes C 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 regulapplication 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:
	C No more than one period within a calendar year.
	(No more than one period within two calendar years.
	C No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
	C Other reasonable limitation:
The	state requires that a written application be signed by the applicant, parent or representative, as appropriate.
	Yes C No
	C 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.

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TN No: 13-0026-MM7 South Carolina Approval Date: 12/17/15 S-21-2

Effective Date: 01/01/14

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CINA SOL GIRA ADD A MENTIONED	Medicaid Eligibility
The presumptive eligibilit	y determination is based on the following factors:
being determined (e.g	corical or non-financial eligibility for the group for which the individual's presumptive eligibility is , based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements aid state plan or a Medicaid 1115 demonstration for that group)
Household income mu eligibility is being det	ist not exceed the applicable income standard for the group for which the individual's presumptive ermined, if an income standard is applicable for this group.
State residency	
Citizenship, status as	a national, or satisfactory immigration status
$\square The state assures that it has conhospitals. A copy of the training$	nmunicated the requirements for qualified hospitals, and has provided adequate training to the ag 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.

TN No: 13-0026-MM7 South Carolina Approval Date: 12/17/15 S-21-3 Effective Date: 01/01/14

Healthy Connections



Medicaid Presumptive Eligibility

South Carolina Department of Health and Human Services

PRIORITY PROCESSING This is not a full Medicaid application



Who is authorized to complete this application?

Who is eligible for

this program?

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.

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.

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things to know

Where can I find resources to help complete this application?

- Visit <u>scdhhs.gov</u> 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: <u>http://medicaidelearning.com</u>.

PRIORITY PROCESSING This is not a full Medicaid applic	ation						
	ell us about	: the in	divid	lual		PRESUMI	PTIVE TY
All fields on this form are required unless noted a	is optional.				-		
1. First name, middle name, last name and suffix	······	-	Relati SEL		to PERS	ON 1	
2. Date of birth (mm/dd/yyyy) 3. Sex:	Female			-			
4. Home address (Leave blank if you don't have one.)					5. Apart	ment or suit	e numbe
6. City	7. State	8. ZIP o	ode	9. 0	County		
10. Mailing address (if different from home address)	····	<u> </u>			11. Apart	ment or suit	e numbe
12. City	13, State	14. ZIP	code	15.	County	Westernessen gen - Courte, Courternessen	
16. Phone number (Leave blank if you don't have one.) ()	17. E-mail ad	dress (Leav	e blank	 if you	don't hav	/e 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? a. If yes, how many babies are expected? Note: PE coverage for pregnant women is limited to ambu			over labo	or and	delivery.	Yes	No
Healthy Connections will follow up with the individu	al to apply for furthe	r coverage.					
23. Is this person a parent or caretaker relative?						☐ Yes	☐ No
24. Has the applicant been diagnosed with / receiving tra- • Breast Cancer • Cervical Cancer • Atypical Breast Hype		i the followi ous Cervical Le		2/3)		Yes	No
25. Was the applicant enrolled in Medicaid and in foster	care in South Card	olina at age	18 or ol	der?		Yes	No
26. INCOME (Write the total income before taxes are tak	en out.) Do not le	ave this fic	ld blan	k.			
▼ Job income For example, wages, salaries, and self-	employment incom	e.					
Amount \$ How often? (check one) 🔲 W	eekly 🗌 I	Biweekly	, 🗆	Monthly	🗌 Yearly	
Other income For example, unemployment check Administration (SSDI). Do not include Supplement							
Amount \$ How often? (check one) 🔲 W	eekiy 🗌 i	Biweekly	, 🗆	Monthly	🗌 Yearly	
DHHS Form 3402 (November 2015). TN No: 13-0026-MM7 Appro South Carolina	val Date: 12/17 2	/15	Effec	tive l	Date: 01	/01/14	

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 Relationsh				ON 1	
2. Date of birth (mm/dd/yyyy) 3. Sex:	Female				
4. Home address (Leave blank if you don't have one.)			5. Apart	ment or suit	e number
6. City	7. State	8. ZIP code	9. County		Minifi-uti-annormaniana
10. Mailing address (if different from home address)			11. Apart	ment or suite	e number
12. City	13. State	14. ZIP code	15. County		Ver
16. Phone number (Leave blank if you don't have one.)	17. E-mail ad	dress (Leave blank	if you don't hav	/e one.)	******
18. Does this person need health coverage? If "No", go t	to question 26.		annen er en annen den an frider og skiller skiller de sok gange	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? a. If yes, how many bables are expected? Note: PE coverage for pregnant women is limited to ambu Healthy Connections will follow up with the individu	ulatory prenatal care	. It does not cover lab	oor and delivery.	Yes	No
23. Is this person a parent or caretaker relative?	ne men en e	e waanna ahaa magamaan waxaa waxaa ahaa ahaa ahaa ahaa ahaa ah		Yes	No
24. Has this person been diagnosed with / receiving treases • Breast Cancer • Cervical Cancer • Atypical Breast Hype		the following? ous Cervical Lesion (CIN	2/3)	☐ Yes	No
25. Was this person enrolled in Medicaid and in foster c	are in South Carol	ina at age 18 or old	ler?	Yes	🗋 No
26. INCOME (Write the total income before taxes are tal			nk.		
Job income For example, wages, salaries, and self-					
Amount \$ How often? V Other income For example, unemployment che		/eekly 🔲 Biweek sability payments fi		•	
Administration (SSDI). Do not include Suppleme	ental Security Incor	ne (SSI) or any child	d support you re	eceive.	
	(check one) 📙 W	/eekly 🗌 Biweek	ly Ll Monthly	L Yearly	400.000 000 000 000 000 000 000 000 000
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PRIORITY PROCESSING This is not a full Medicaid application STEP 1: PERSON 3 PRESUMPTIVE ELIGIBILITY Tell us about the individual's family. 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? **No** Yes 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.

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	Amount \$	How often? (check one) 🔲 Weekly 🗌 Biwee	kly 🗌 Monthly 🗌 Yearly
A		nployment checks, alimony, or disability payments lude Supplemental Security Income (SSI) or any ch	
	Amount \$	How often? (check one) 🗌 Weekly 🗌 Biwee	kly 🗌 Monthly 🗍 Yearly
TN N	m 3402 (November 2015). Io: 13-0026-MM7 h Carolina	Approval Date: $12/17/15$ Effe	ctive Date: 01/01/14

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7. State	8. ZIP c	ode	9. Cou	Inty		
			1	. Apartm	ent or suite	e number
13. State	14. ZIP	code	15. Co	unty		
17. E-mail ad	dress (Leave	e blank il	f you do	on't have	one.)	
uestion 26.					Yes	No
				·	Yes	No
491994497-10-01-01-01-01-01-01-01-01-01-01-01-01-					Yes	No
					Yes	No
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					Yes	No
ory prenatal care.	It does not o	over labo	r and de	livery.		
	anna a na ann an Anna an Anna Anna Anna				[] Yes	<u></u> <u> </u> <u> </u> No
			/3)		Yes	No
in South Carol	na at age 1	8 or olde	er?		[]Yes	No
out.) Do not le	ave this fie	d blani	K.			
ployment incom	e.					
eck one) 🗌 W	eekly	Biweekly	и□и	onthly	🗌 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.						
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PRIORITY PROCESSING This is not a full Medicaid			
STEP 2 Sign this app	lication		PRESUMPTIVE ELIGIBILITY
Signature of applicant/individual listed in Store	ep 1 (Optional)		Date (mm/dd/yyyy)
STEP 3 Return the c	ompleted app	lication.	PRESUMPTIVE ELIGIBILITY
Mail your signed application to: SCDHHS PO Box 100101 Columbia SC 29202-3101	-OR-	Fax your signed appli (803) 255-8253	cation to:

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