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State/Territory Name: South Carolina

State Plan Amendment (SPA) #:15-0005

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Page

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

June 1, 2015

Mr. Christian L. Soura
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

Re: South Carolina State Plan Amendment 15-005

Dear Mr. Soura:

We have reviewed the proposed South Carolina state plan amendment, 15-005, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on May 22, 2015. This amendment updates the name of the designee that is authorized to submit state plan amendments for the South Carolina Department of Health and Human Services.

Based on the information provided, the Medicaid State Plan Amendment SC 15-005 was approved on June 1, 2015. The effective date of this amendment is April 1, 2015. We are enclosing the approved HCFA-179 and a copy of the new state plan page.

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

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:
SC 15-005

2. STATE
South Carolina

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

4. PROPOSED EFFECTIVE DATE
April 1, 2015

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:
42 CFR 430.12 (b) (2)

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 \$ 0
b. FFY 2016 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Basic Index, page 89

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Basic Index, page 89

10. SUBJECT OF AMENDMENT:

This plan updates the name of the designee to submit State Plan Amendments (SPAs).

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. Soura was designated by the Governor
to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Christian L. Soura

14. TITLE:
Director

15. DATE SUBMITTED:
May 21, 2015

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 05-22-15

18. DATE APPROVED: 06-01-15

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
04-01-15

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB NO. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

Citation (s) 7.4 State Governor's Review

42 CFR 430.12 (b)

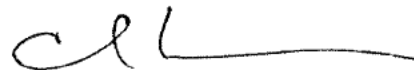
The Medicaid agency will provide opportunity for the office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

- ☒ Not applicable. The Governor--
- ☒ Does not wish to review any plan material.
- ☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plans on behalf of
South Carolina Department of Health and Human Services

(Designated Single State Agency)

Date: April 1, 2015



(Signature)

Director
(Title)

TN No.: SC 15-005

Supersedes Approval Date: 06/01/15 Effective Date: 04/01/15

TN No.: SC 08-002