DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

aTRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 09-011

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
July 1, 2010

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:
In accordance with federal regulations (42 CFR 440.130)

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $750,000
b. FFY 2011 $3.000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Limitation Supplement Pages 6b, 6c thru 6c.13
Attachment 4.19-B, Pages 6.1 thru 6.1d

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A, Limitation Supplement Page 6b & 6c
Attachment 4.19-B, Page 6.1

10. SUBJECT OF AMENDMENT:
This SPA relates to rehabilitation services related to behavioral health. The rehabilitation option (42 CFR 440.130) appears to be the appropriate coverage section for the services being described in this SPA.

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:

13. TYPED NAME:
Emma Forkner

14. TITLE:
Director

15. DATE SUBMITTED:
November 30, 2009

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 11/30/09

18. DATE APPROVED: 05/27/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
for Jackie Glaze

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

23. REMARKS:

Following changes:

Block #8 Attachment 3.1-A, Limitation Supplement Pages 6b, 6c thru 6c.13 and Attachment 4.19-B , pages 6.1 thru 6.1d changed to read: Attachment 3.1-A, Limitation Supplement Pages 6b, 6c thru 6c.16 and 4.19-B pages 6.1 thru 6.1f