

Generic Supporting Statement
State Plan Amendment (SPA) Template for
1905(a)(29) of the Social Security Act Medication Assisted Treatment (MAT)
(CMS-10398 #68, OMB 0938-1148)

This April 2025 iteration is being submitted to OMB for approval as a revised generic collection of information request.

Please note that our active collection is entitled, “Section 1006(b) of the SUPPORT Act: Medicaid Assisted Treatment (MAT)” and that we are revising the title (as indicated above) to reflect the 1905(a) statutory authority which is more accurate.

A. Background

The Centers for Medicare & Medicaid Services (CMS) work in partnership with States to implement Medicaid and the Children’s Health Insurance Program (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates for States to use to elect new options available as a result of the Affordable Care Act to comply with new statutory provisions. CMS also continues to work with States through other methods to further the goals of health reform, including program waivers and demonstrations, and other technical assistance initiatives.

Under section 1902(a)(10) of the Social Security Act (the Act), States may offer certain Medicaid benefits, at State option, to categorically needy and medically needy Medicaid beneficiaries. In 2018, section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (herein referred to as the SUPPORT Act) (Pub. L. 115-271) established mandatory coverage of medication-assisted treatment (MAT) as a new Medicaid state plan benefit by adding section 1905(a)(29) of the Act for October 1, 2020 through September 30, 2025. On December 30, 2020, CMS issued State Health Official Letter (SHO) #20-005 entitled, “Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment”¹ Which describes the requirements of the mandatory MAT benefit and opportunities for increasing treatment options for substance use disorders (SUDs), as described at section 1905(a)(29) of the Act and the process for an exemption from the mandatory coverage requirement if there was a documented shortage of qualified providers or facilities providing such treatment in either fee-for-service or managed care arrangements in accordance with section 1905(ee)(2) of the Act.

On March 9, 2024, section 201 of the Consolidated Appropriations Act, 2024 (CAA, 2024; Pub. L. 118-42) made the mandatory MAT benefit at permanent. Section 201 also amended section 1905(ee)(2) of the Act to allow states to request an exemption from the mandatory coverage

¹ SHO #20-005: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf>.

requirement due to a documented provider shortage if the state re-certifies not less than every five years and to the satisfaction of the Secretary that the provider shortage continues. The process to request an exemption will be conducted every five years and is the same as described in SHO #20-005 except for and, as noted, the reference to the limited timeframe of this provision which has been removed.

On November 19, 2024 CMS issued [State Medicaid Director Letter \(SMD\) # 24-004](#) entitled “Extension of Medicaid Coverage of Substance Use Disorder Treatment and Managed Care Medical Loss Ratio Provisions in the Consolidated Appropriations Act, 2024”, providing subregulatory guidance to states regarding these requirements.²

The amendments to the Act as a result of the passage of the SUPPORT Act and section 201 of the CAA, 2024, as well as the subregulatory guidance provided in SMD #24-004 provides the authority for States to add this mandatory Medicaid coverage for MAT. In this April 2025 iteration, we propose to update an active SPA template to comport with the statutory updates as described above now that the benefit is permanent.

B. Description of Information Collection

The SPA template consists of a SPA benefit checkoff page for the mandatory benefit labeled attachment 3.1 (also called a preprint page) for item 1905(a)(29). States must complete an Attachment 3.1-A page form and by selecting that label from the pull-down menu to describe coverage for category needy beneficiaries. If states cover medically needy only beneficiaries, they also must also complete an Attachment 3.1-B form, however some states have language in their state plan indicating they cover both groups as outlined in 3.1-A pages for all benefits.

The SPA template also includes the benefit detail page labeled Supplement to Attachment 3.1. Supplement 3.1 template pages requests the following information:

*General Assurances – **The only section with substantive changes.***

States must select the three checkboxes on the first page to confirm they are compliant with the statute.

Service Package

States must describe in the three freeform text fields: 1) the counseling services and behavioral health therapies included as part of MAT, 2) the providers furnishing services, and 3) summary of the qualifications for each practitioner or provider entity including any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

Utilization Controls

States must select the applicable checkboxes to indicate which utilization controls (or none) are in place.

Limitations

² <https://www.medicaid.gov/federal-policy-guidance/downloads/smd24004.pdf>.

States must describe in the freeform text field any limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

The form will be disseminated through multiple avenues:

- announced through a Medicaid.gov email blast, which will include a link to a downloadable version of each template, and
- available upon request through the state lead points of contact.

States will submit these amendments through [the One Medicaid and Chip \(OneMAC\) System](#) online submission portal where states can upload completed (PDF or word) state plan pages. This portal was created to replace the previous email submission process with a standard point of submission. Please note, OneMAC accepts submissions independently and not affiliated with the MACPro or MMDL system or process. Technical Assistance in submitting these plan pages will be available from state lead points of contact and for overall content from the Division of Benefits and Coverage.

Medicaid State plans are public documents generally available on the Internet. However, there are no plans to publish the information specifically for statistical use.

The approved submitted SPAs are publicly posted to [Medicad.gov](#). In accordance with 42 CFR 430.20, the effective date of a SPA may be no earlier than the first day of the quarter it was submitted (with the exception of section 1915(i) SPAs which must be approved with a prospective effective date). CMS review time can vary, based on any revisions needed by the state. Generally, they are submitted and CMS has 90 days to review and approve or disapprove a submission, or respond with a formal Request for Additional Information (RAI). The state's timeline for a response is indeterminate, generally less than 90 days. Once a response is received, CMS has 90 days to review and approve or disapprove the submission. The timeline is not expected to exceed 270 calendar days, but can be as little as 2 days for simple approvals involving no revisions or requests for additional information.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

Wage Estimates

To derive average costs, we are using data from the U.S. Bureau of Labor Statistics' May 2024 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

BLS’s wage estimates are updated annually. Current and historic wage figures can be found at the above BLS address and can be used to calculate current cost estimates. May 2024 (see above) is current as of the date of this collection of information request.

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Business Operations Specialist	13-1000	43.76	43.76	87.52
General and Operations Manager	11-1021	64.00	64.00	128.00

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Requirements and Associated Burden Estimates

States should update their state plan pages as benefit components are updated and at a minimum must update the 1st page of the Supplement to Attachment 3.1 before September 30, 2025. States must submit their SPA no later than the end of the quarter in their effective date falls.

The Medicaid respondents consist of all 50 States, the District of Colombia, American Samoa, Commonwealth of the Mariana Islands, Guam, Puerto Rico, and the US Virgin Islands. In aggregate, we estimate a potential of 56 respondents.

We estimate it will take a Business Operations Specialist 22 hours at \$87.52/hr to include the time to prepare an initial SPA updating the first Supplement page to remove the benefit end date, make occasional and periodic updates to the SPA pages based on benefit updates, complete and confirm public notice requirements, verify requirements compliance, and compile and document any additional information needed for the freeform text boxes. We also estimate that it will take a General and Operations Manager 3 hours at \$128.00/hr to review and approve the SPA for submission to CMS.

In aggregate we estimate a one-time state burden of 1,400 hours (56 states x 25 hr/response) at a cost of \$129,329 [(22 hr x \$87.52/hr x 56 states) + (3 hr x \$128.00/hr x 56 states)].

Since we have no reliable basis for estimating the number of template amendments we may receive each year, the 1,400-hour estimate is an annual figure that addresses the one-time burden at the beginning of the effort as well as the occasional burden for preparing and submitting amendments. We acknowledge that this is likely an overestimate, but we will refine our estimate if/when applicable.

Burden Summary

Requirements	Number of Respondents	Total Number of Responses	Time per Response (hours)	Total Time (hours)	Labor Rate (\$/hr)	Total Cost (\$)
Attachment 3.1 (A and B) and Supplements)	56 States	56	25	1,400	varies	129,329
TOTAL	56 States	56	varies	1,400	varies	129,329

Information Collection Instruments and Instruction/Guidance Documents

CMS has updated the following SPA templates to minimize the burden to states in satisfying the subject state plan submission requirements. Instructions for their completion are provided on the form. The template is a fillable form PDF.

The template includes pages which are labeled Attachment 3.1 and Supplement to Attachment 3.1 - indicating where the pages are located in the state plan. If states cover medically needy only beneficiaries, they also must also complete an Attachment 3.1-B form, however some states have language in their state plan indicating they cover both groups as outlined in 3.1-A pages for all benefits.

Previously these were issued as two separate documents, but for ease of completion we have combined 3.1-A and 3.1-B as one document with a drop-down options box so that states may easily replicate and edit any variation when they offer coverage for both categorically needy and medically needy only beneficiaries, and use both pages in their state plan.

The template consists of multiple sections for states to complete via checkboxes and text boxes and updates are listed below as follows:

Attachment 3.1 is represented by the first page in the template indicating coverage of the MAT benefit in the state plan. This update added a checkbox and revised header and footers to reduce submission errors in labeling pages. Supplement to Attachment 3.1 on the subsequent pages provide further benefit coverage detail and includes added checkboxes, revised header and footers, prompt to assist with completion and an update to the General Assurances section to remove the benefit end date.

E. Timeline

The 14-day notice published in the Federal Register on April 16, 2025 (90 FR 15987). Comments must be received by April 30, 2025.

CMS hopes to deploy this collection within 30 - 45 days from our submission to OMB. These Medicaid state plan documents are essential for states updating their current benefit. At the latest, they are necessary for states to submit a state plan amendment on or before September 30, 2025, for a September 30, 2025, effective date.