Context:

Definitions:

- SPA: state plan amendment
- CMS: Centers for Medicare and Medicaid Services
- RAI: Request for Additional Information

Content:

- The following content is sourced from the SPA Submission and Processing for State Medicaid Staff Training. Each slide begins with a **bold** text.

Introduction

Each state and territory is required to have a Medicaid State Plan, that documents:

- who is eligible,
- what services are covered, and
- how the state will reimburse providers.

To make changes to a State Plan, states submit a State Plan Amendment (SPA) to CMS for approval. States and territories submit multiple SPAs each year.

The requirements, processes, and submission systems for SPAs are complex.

CMCS developed this training to help our state partners understand the SPA submission requirements and submission process.

(1) Medicaid State Plan Structure

- Single State Agency Organization
- Eligibility
- Coverage
- General Program Administration
- Personnel Administration
- Financial Administration
- General Provisions
- MAGI
- MACPro

(2) SPA Processing Overview

- In general, a SPA review consists of the CMS team asking questions and/or suggesting revisions to the submitted pages, and the state staff providing responses and revised

documents. This cycle may happen multiple times before the final version of the SPA is mutually agreed on.
    - Each SPA review process starts with a call to discuss the purpose and context of the SPA, and for the CMS review team members to ask any initial questions they have. CMS tries to schedule these calls within 15 days of the SPA submission, so we call them “15-day calls.”

- Under section 1915(f) of the Social Security Act, CMS must approve, disapprove, or request additional information on a SPA within 90 days of submission or the amendment is deemed approved.
- The 90-day time period can be stopped only once by a formal, written request for additional information from CMS, called an RAI. Upon receipt of the requested information from the state, a new 90-day clock is initiated.
- CMS can also request additional information informally, which is called issuing clarification. Clarifications do not stop the 90-day clock.
- States can withdraw SPA submissions at any point during the review process.

The 90 day clocks:
- *First 90-day clock:* SPA submitted: the 15-day call takes place: state staff proved a high-level overview of the SPA. Informal questions and responses are typically send during the period
    - When SPAs are approved during the first 90-day clock, no RAI is issued and there is no second clock
- *Off the Clock:* RAI issued. The 90-day clock stops the day CMS issues the RAI
- *Second 90-day Clock*: RAI responses submitted. The 2nd 90-day clock starts the day the State submits responses to the RAI
- *SPA Approval*

(3) SPA Submission Systems

Currently there are three SPA submission systems:
- OneMAC: All SPAs not submitted to MACPro or MMDL - https://onemac.cms.gov/
- MACPro: Administrative, Health Homes, and most eligibility SPAs - MACPro login-IDM homepage
- Medicaid Model Data Lab (MMDL): Alternative Benefit Plan (ABP) and certain cost-sharing SPAs - https://wms-mmdl.cms.gov/MMDL/faces/portal.jsp.

Most SPAs are submitted through OneMAC. Any SPA that does not fit the criteria for MACPro or MMDL (on the next slides) should be submitted through OneMAC.

OneMAC is an submission portal for “paper-based” SPAs and formal responses to Requests for Additional Information (RAIs).

Responses and revisions related to informal questions (clarifications) are submitted directly to the SPA’s CMS Point of Contact via email.

Detailed information about the OneMAC submission process, onboarding materials, and helpdesk are available in the FAQs tab on onemac.cms.gov (log-in is not required to access these resources).
OneMac User Roles for State Users:

1. State Submitter
    a. Actions Creates new paper-based submissions, submits packages, and submits official RAI responses to CMS for review: (medicaid SPAs, 1915(b) waivers, 1915(c) waivers)
    b. Role Approver: State System Admin
2. State System Administrator
    a. Actions: Reviews and acts on State Submitter user role requests and system access, has all State Submitter Permissions
    b. Role Approver: CMS Role Approver

MacPro:
MACPro is a web-based application for the submission, review, and disposition of three types of SPAs:

- Administration
- Eligibility
- Health Homes

Instead of SPA pages, MACPro contains Reviewable Units (RUs) with structured data forms.

All SPA related actions are conducted in the system, including:

- CMS requests for clarification and state responses,
- Reviewable Unit revisions,
- Formal RAIs and state formal response to RAI, and
- Draft SPA submissions

Access MACPro at: macpro.cms.gov

Most eligibility SPAs are submitted to MACPro, including:

- All mandatory and optional Eligibility Groups
- Financial methodologies used to determine eligibility,
- Income and resource standards used to determine eligibility
- Presumptive eligibility

This means that most of the SPAs that would have included pages from Section 2, Attachments 2.2-A, or 2.6-A in the paper State Plan; or A1-A3, or any MAGI page in MMDL, are submitted using the corresponding MACPro RUs.

Eligibility SPAs NOT submitted to MacPro:

- OneMAC (paper-based) SPAs
    - Post-Eligibility Treatment of Income (PETI)
    - Third Party Liability (TPL)

        - Express Lane Eligibility (ELE)
        - Premium elections and methodologies (Attachments 2.6 and 4.18 in the paper-based State Plan)
- MMDL SPAs
- Cost-Sharing
    - Premiums
        - Assurances of compliance with limits on cost-sharing and premiums (42 CFR 447.56).

Health Home SPAs

- In May 2016, CMS migrated all Health Homes SPAs originally submitted and approved using MMDL to MACPro.
- Since then, all Health Homes amendments are submitted in MACPro.

MMDL Medicaid Model Data Lab

- MMDL is a web-based PDF repository used for the submission of two types of SPAs:
    - Premium and Cost Sharing
    - Alternative Benefit Plans (ABPs)
- MMDL contains fillable PDF forms and implementation guides for these SPAs. The PDF forms are the actual SPA pages; the implementation guides describe the relevant regulations and policies and technical guidance.
- Access MMDL at: https://wms-mmdl.cms.gov/MMDL/faces/portal.jsp
- For ABP SPAs, states should submit amendments to existing MMDL records rather than creating new packages. For cost-sharing SPAs, states should create new records.
- For SPAs submitted in MMDL, correspondence between CMS and the state is conducted by email; revisions to the PDF forms are submitted in MMDL.

(4) SPA Submission Packages

SPA submission packages must include the following (by submission system):

1. OneMac
    a. Pages: State Plan Pages
    b. CMS 179 Form: CMS 179 Form
2. MacPro
    a. Pages: Reviewable Units
    b. CMS 179 Form: Submission Form
3. MMDL
    a. Pages: PDF Forms
    b. CMS 179 Form: Summary Page (CMS 179)

SPAs must also include, as applicable:

- Documentation of public notice
- Documentation of tribal consultation

Depending on the type of submission additional documents may be required

Documentation of public notice is required for SPAs that:

- Changes methods and standards for setting payment rates (42 CFR 447.205)
- Establish or modify Medicaid premiums or cost-sharing (42 CFR 447.57(c))
- Establish or modify an ABP (42 CFR 440.386)

The timelines and content requirements for these 3 types of SPAs are different.
Public notice timing will impact the effective date of the SPA. It is important to plan in advance to avoid effective date delays resulting from incomplete or late public notice.

Further resources and details about federal public notice requirements for changes to Medicaid payment rates can be found in the June, 2016 CMCS Informational Bulletin

Please consult with your CPOC in advance if you have questions about federal public notice requirement for a specific SPA.

Federal law and CMS guidance require states to solicit advice from Indian Health Care Providers before submitting SPAs to CMS:

- 1902(a)(73) of the Social Security Act
- 42 CFR 431.408
- SMDL #01-024

The State plan must describe the process for soliciting advice prior to submission on matters that have a direct impact on Indians, Indian Health Programs, or Urban Indian Organizations, such as Medicaid SPAs, 1915 waivers, CHIP programs, and 1115 demonstrations. All State plans have a description of their tribal consultation requirements and process in Section 1.4-Adminstration.

States must include documentation of tribal consultation in the SPA submission package when required.

< Tribal Consultation Letter Examples>

SPAs that include reimbursement pages (in Attachments 4.19-A, 4.19-B, or 4.-19-D) must include answers to the Standard Funding Questions

(5) The CMS-179 Form
A completed, signed and dated CMS-179, or Submission Summary for SPAs submitted using MMDL or MACPro, must be included with all SPA packages.

The 179 provides pertinent information on many aspects of the SPA.

A fillable CMS 179 Form and instructions for completing it are posted on Medicaid.gov

(6) Effective Date Requirements
Per regulations, the effective date of a SPA can be no earlier than the first day of the quarter it was submitted in.

- Example – Earliest possible effective date for a SPA submitted on March 30 is January 1.

For all SPAs affecting reimbursement methods and payments, public notice must begin at least one day prior to the effective date of the SPA.

- Example: if public notice begins on January 1, earliest possible effective date is January 2.

For SPAs affecting premiums and cost-sharing or ABPs, public notice must begin prior to the SPA's submission to CMS. The general rule about effective dates being no earlier than the first day of the quarter also applies.

- Example – if public notice begins March 31, earliest possible submission date and effective date is April 1.

(7) CMS Review Team Roles

The Center for Medicaid and CHIP Services (CMCS) is responsible for the program policies and operations related to Medicaid.

SPA review teams are comprised of members from several different Groups within the Center with specific subject matter area expertise.

CPOC (CMS Point of Contact)

- CMS staff person, usually from the lead division, who serves as the state's main point of contact during a SPA review.
- The individual assigned the CPOC role depends on the content of the SPA.

SMEs (Subject Matter Expert)

- Typically, one or more CMS SMEs are assigned to the review team to address specific policy areas in the submission.
- The SMEs assigned to the review team depend on the content of the SPA.

It is most efficient if states can direct questions and other correspondence to the CPOC leading the SPA.

State Leads are the CPOCs for many types of SPAs, such as:

- all disaster relief SPAs (Section 7)
- SPAs that include both coverage (3.1 A and B) and reimbursement (4.19 A, B, or D) pages
- Eligibility SPAs (MACPro or MMDL; Attachment 2 when submitted through OneMAC)

DRR analysts are the CPOCs for SPAs that only include reimbursement pages from Attachment 4.19-A, B, or D

Pharmacy analysts are the CPOCs for SPAs that include pages from Attachment 3.1-A item 12a; Attachment 4.19-B item 12a; or Section 4.26.

The CPOCs for other types of SPAs come from other CMCS Groups and Divisions. For example:

- Pharmacy SPAs (Managed care (Attachment 3.1F) and PACE SPAs (Attachment 3.1A) are led by an analyst from the Division of Managed Care Operations (DMCO)
- 1915(i), 1915(k), and 1915(j) SPAs (various locations within Attachment 3.1A) are lead by an analyst from the Division of HCBS Operations (DHCBSO)

System Links and System Resources
MMDL - https://wms-mmdl.cms.gov/MMDL/faces/portal.jsp
MMDL Helpdesk - https://wms-mmdl.cms.gov/MMDL/mmdlHelpDesk.html
Medicaid SPA Toolkit – guidance on submissions and policy for many types of SPAs
CMS 179 Form
CMCS Organizational Chart – see page 39
Public Notice/Public Process requirements
Standard Funding Questions