

Generic Supporting Statement
3.1-M State Plan Amendment (SPA) Templates for
Eligible Juveniles Who are Inmates of a Public Institution
(CMS-10398 #85, OMB 0938-1148)

This November 2024 iteration is being submitted to OMB for approval as a new generic collection of information request under control number 0938-1148.

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 or 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.

Section 5121 of the Consolidated Appropriation Act of 2023 (CAA, 2023) creates a new mandate for states by amending section 1902(a)(84) of the Social Security Act (the Act) (42 U.S.C. 1396a) to require states to provide specific screening and diagnostic services and targeted case management (including referrals) in the 30 days prior to release from incarceration, and targeted case management (TCM)¹ (including referrals) for at least 30 days post release for eligible juveniles² who are inmates of a public institution, post adjudication. The requirements are effective January 1, 2025.

¹ Sections 1905(a)(19) and 1915(g)(2) of the Social Security Act (the Act) define Medicaid case management as services that will assist an individual eligible under the state plan in gaining access to needed medical, social, educational, and other services. Medicaid case management services are referred to as “targeted case management services” when the services are not furnished in accordance with Medicaid statewideness or comparability requirements. The flexibility associated with TCM services enables states to target case management services to specific populations and/or to individuals who reside in specified areas. TCM is defined in regulation at 42 CFR 440.169(b); see <https://www.medicaid.gov/federal-policy-guidance/downloads/smd011901c.pdf>.

² For purposes of section 1902(a)(84) of the Act, section 1902(nn) of the Act defines “eligible juvenile” as an individual who is an inmate of a public institution, and is under 21 years of age determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory eligibility group for former foster care children), who was determined eligible for Medicaid before becoming an inmate of a public institution or who is determined eligible for Medicaid while an inmate of a public institution. Individuals described in the mandatory eligibility group for former foster care children, implemented at 42 CFR 435.150, include individuals under age 26 who meet the criteria for the group upon attaining either age 18 or such higher age (up to 21) as the state or tribe has elected for termination of federal foster care assistance under title IV-E of the Act. This was described further in SMD 21-002, issued on January 19, 2021. Thus, “eligible juvenile” in the statute also includes former foster care children between 18 and 26 years old.

To comply with the amendments made by section 5121 of the CAA, 2023, states must submit a Medicaid SPA attesting that the state has developed an internal operation plan, and in accordance with such plan, will provide coverage during the statutory pre- and post-release period of screening, diagnostic, and TCM services for eligible juveniles who are within 30 days of release post adjudication.

Additionally, Section 5122 of the CAA, 2023 amended section 1905(a) of the Act, section 1902(a)(84)(A) of the Act, and section 2110(b)(7) of the Act to allow states the option to lift the Medicaid inmate payment and CHIP eligibility exclusions and provide coverage of pre-release Medicaid and CHIP services (for electing states), and makes available federal matching funds for the full breadth of Medicaid and CHIP benefits to eligible juveniles who are incarcerated and pending disposition of charges. States selecting this state plan option must provide to eligible juveniles all mandatory and optional services to which they are otherwise entitled under the state plan. During the period when an eligible juvenile is incarcerated and pending disposition of charges, this is essentially a full lifting of the Medicaid inmate payment exclusion and CHIP eligibility exclusion. States cannot choose to provide a limited array of state plan services under this option. An operational plan is not required for this state option.

For states that wish to elect the option in section 5122 of the CAA, 2023, states should submit a SPA attesting to CMS that they are also electing coverage for any Medicaid or CHIP state plan services for eligible juveniles pending disposition of charges to which the beneficiary would otherwise be entitled, if not for their incarceration status.

The amendments to the Act (as a result of the passage of the CAA 2023) and SHO #24-004 provide the authority for mandatory state plan amendments to add such coverage.

[State Health Official \(SHO\) letter #24-004](#) outlines the aforementioned requirements in more detail.

In order to have an effective date of January 1, 2025, states must submit their SPA no later than the end of the quarter in which January 1, 2025, falls, which is March 31, 2025. The establishment of templates for these coverage pages are submitted to OMB for approval through the generic PRA process specified in the CMS-10398 Supporting Statement part A that was last approved by OMB on October 3, 2024³. The three templates consist of:

- Attestation for Mandatory Coverage of Eligible Juveniles (Attachment 3.1-M pages 1 and 2)
- Attestation for Optional Coverage of Eligible Juveniles (Attachment 3.1-M page 3)
- TCM for Mandatory Coverage of Eligible Juveniles (Supplement to Attachment 3.1)

B. Description of Information Collection

Attestation for Mandatory Coverage of Eligible Juveniles (Attachment 3.1-M pages 1 and 2)
States must select the three checkboxes on page 1 to confirm they are compliant with the components of the statutory requirements of section 5121 of the CAA, 2023. A freeform text

³ https://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=202409-0938-028

field is provided on page 2 for states to use to communicate with CMS any additional relevant information related to the submission (e.g. that another SPA is in the approval process in order to meet the requirements).

Attestation for Optional Coverage of Eligible Juveniles (Attachment 3.1-M page 3) Must be completed and submitted by states wishing to provide the optional full state plan coverage. States must select single checkbox on this page to indicate they are electing this coverage made available by section 5122 of the CAA, 2023. A freeform text field is provided for states to use to communicate with CMS any additional relevant information related to the submission.

TCM for Mandatory Coverage of Eligible Juveniles (Supplement to Attachment 3.1) For states to establish coverage pages for a TCM specific to this population as required by the section 5121 of the CAA, 2023. This template includes the mandatory statutory regulatory requirements for state plan submissions and includes checkboxes and freeform text boxes for states to communicate their state specific provider qualifications and monitoring approaches or any other requirements and limitations allowable for the targeted case management benefit in accordance with the mandatory coverage of eligible juveniles.

The forms 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 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 2023 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/2023/may/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 wage figures can be found at http://www.bls.gov/oes/current/oes_nat.htm and can be used to calculate current cost estimates. May 2023 (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	42.33	42.33	84.66
General and Operations Manager	11-1021	62.18	62.18	124.36

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, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Requirements and Associated Burden Estimates

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

Attestation for Mandatory Coverage of Eligible Juveniles
(Attachment 3.1-M pages 1 and 2)

States must select the three checkboxes on page 1 to confirm they are compliant with the components of the statutory requirements of section 5121 of the CAA, 2023.

A freeform text field is provided on page 2 for states to use to communicate with CMS any additional relevant information related to the submission (e.g. that another SPA is in the approval process in order to meet the requirements).

We estimate it will take a Business Operations Specialist 40 hours at \$84.66/hr to include the time for preparing the initial internal operation plan for initial implementation (which does not need to be submitted to CMS, except upon request as indicated in SMD #24-004), including occasional updates to the plan, complete and confirm public notice requirements, verify requirements compliance, and compile and document any additional information needed for the freeform text box. We also estimate that it will take a General and Operations Manager 10 hour at \$124.36/hr to review and approve the SPA for submission to CMS .

In aggregate we estimate a one-time state burden of 2,800 hours (56 states x 50 hr/response) at a cost of \$259,280 [40 hr x \$84.66/hr x 56 states) + (10 hr x \$124.36/hr x 56 states)].

Since we have no reliable basis for estimating the number of template amendments we may receive each year, the 2,800-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.

Attestation for Optional Coverage of Eligible Juveniles
(Attachment 3.1-M page 3)

The attestation must be completed and submitted by states wishing to provide the optional full state plan coverage. States must select single checkbox on this page to indicate they are electing this coverage made available by section 5122 of the CAA, 2023.

We estimate it will take a Business Operations Specialist 20 hours at \$84.66/hr to confirm readiness and compliance with operational areas, complete and confirm public notice requirements, verify requirements compliance, and complete the attestation. We also estimate that it will take a General and Operations Manager 2 hours at \$124.36/hr to review and approve the SPA for submission to CMS.

In aggregate we estimate a one-time state burden of 1,232 hours (56 states x 22 hr/response) at a cost of \$108,748 [20 hr x \$84.66/hr x 56 states) + (2 hr x \$124.36/hr x 56 states)].

Since we have no reliable basis for estimating the number of template amendments we may receive each year, the 1,232-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.

Targeted Case Management (TCM) for Mandatory Coverage of Eligible Juveniles
(Supplement to Attachment 3.1)

The template is intended for states to establish coverage ages for a TCM specific to this population as required by the section 5121 of the CAA, 2023. The template includes the mandatory statutory regulatory requirements for state plan submissions and includes checkboxes and freeform text boxes for states to communicate their state specific provider qualifications and monitoring approaches or any other requirements and limitations allowable for the targeted case management benefit in accordance with the mandatory coverage of eligible juveniles.

We estimate it will take a Business Operations Specialist 13 hours at \$84.66/hr to establish and document the state-specific requirements outlined in the freeform text boxes related to provider qualifications and monitoring, confirm readiness and compliance with operational areas, complete and confirm public notice requirements. We also estimate that it will take a General and Operations Manager 2 hours at \$124.36/hr to review and approve the SPA for submission to CMS.

In aggregate we estimate a one-time state burden of 840 hours (56 states x 15 hr/response) at a cost of \$75,561 [(13 hr x \$84.66/hr x 56 states) + (2 hr x \$124.36/hr x 56 states)].

Since we have no reliable basis for estimating the number of template amendments we may receive each year, the 840-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 (\$)
Attestation for Mandatory Coverage of Eligible Juveniles (Attachment 3.1-M pages 1 and 2)	56 States	56	50	2,800	Varies	259,280
Attestation for Optional Coverage of Eligible Juveniles (Attachment 3.1-M page 3)	56 States	56	22	1,232	Varies	108,748
TCM for Mandatory Coverage of	56 States	56	15	840	varies	75,561

Eligible Juveniles (Supplement to Attachment 3.1)						
TOTAL	56 States	168	varies	4,872	varies	443,588

Information Collection Instruments and Instruction/Guidance Documents

CMS has developed the following three SPA templates to minimize the burden to states in satisfying the subject state plan submission requirements. Instructions for their completion are provided on each form. The templates are fillable form PDFs.

- Attestation for Mandatory Coverage of Eligible Juveniles (Attachment 3.1-M pages 1 and 2)
- Attestation for Optional Coverage of Eligible Juveniles (Attachment 3.1-M page 3)
- TCM for Mandatory Coverage of Eligible Juveniles (Supplement to Attachment 3.1)

Related guidance for the underlying statutory and regulatory requirements are outlined in our July 23, 2024, [State Health Official \(SHO\) letter #24-004](#).

E. Timeline

The 14-day notice published in the Federal Register on November 18, 2024 (89 FR 90705). Comments must be received by December 2.

These Medicaid state plan documents are essential for states implementing the new provisions and helpful to be available as soon as possible. At the latest, they are necessary for states to submit a state plan amendment on or before March 31, 2024, for a January 1, 2025, effective date. States will need adequate time to complete and vet these documents.