

Generic Supporting Statement  
State Plan Amendment (SPA) Template for Medicaid Clinic Benefit  
(CMS-10398 #91, OMB 0938-1148)

This January 2025 iteration is being submitted to OMB 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 (Patient Protection and Affordable Care Act (ACA) (42 U.S.C. 18001, et seq.) 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.

Under section 1902(a)(10) of the Social Security Act (the Act) (42 U.S.C. 1396d), States may offer certain Medicaid benefits, at State option, to categorically needy and medically needy Medicaid beneficiaries, as described in that section of the Act. Clinic services are one of these optional benefit categories.

The regulation implementing section 1905(a)(9) of the Act, 42 CFR 440.90, includes certain conditions and limitations on Medicaid coverage of clinic services. Specifically, § 440.90 defines “clinic services” as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. An “outpatient” is defined at § 440.20 as a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

Section 1905(a)(9) of the Act, as amended by section 4105 of part 1 of subtitle B of title IV of the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87) (Pub. L. 100-203), clarifies Medicaid coverage of “clinic services” includes services “furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address” (hereinafter referred to as “individuals who are unhoused”).<sup>1</sup> Section 440.90 further provides that clinic services include two types of services furnished to outpatients, listed at § 440.90(a) and (b). The first type of services included in the benefit, under

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<sup>1</sup> Pub. L. 100-203, enacted December 22, 1987, 100 Stat. 1330, 1330-147,  
<https://www.congress.gov/100/statute/STATUTE-101/STATUTE-101-Pg1330.pdf>.

§ 440.90(a), is services furnished at the clinic (hereinafter referred to as the “four walls” requirement) by or under the direction of a physician or dentist. Section 440.90(b) implements the statutory language at 1905(a)(9) as clarified by OBRA ’87, providing that clinic services also include services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who is unhoused. In section 4320 of the State Medicaid Manual, CMS explains that if a State elects to cover clinic services, the State may choose the type of clinics or clinic services that are covered.<sup>2</sup>

On November 27, 2024, CMS published the Prospective Payment System and Ambulatory Surgical Center Payment System final rule (CMS-1809-FC, RIN 0938-AV35)<sup>3</sup> which amended § 440.90 to authorize Medicaid coverage for clinic services furnished outside the “four walls” of their clinic by adding paragraphs (c), (d), and (e) to include the following services provided outside of the clinic as follows, referred to as the “four walls exceptions”:

(c) Services furnished outside a clinic that is a facility of the Indian Health Service, whether operated by the Indian Health Service or by a Tribe or Tribal organization (as authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638), by clinic personnel under the direction of a physician.

(d) Services furnished outside of a clinic that is primarily organized for the care and treatment of outpatients with behavioral health disorders, including mental health and substance use disorders, by clinic personnel under the direction of a physician.

(e) Services furnished outside of a clinic that is located in a rural area and is not a rural health clinic (as referenced in section 1905(a)(2)(B) of the Act and § 440.20(b)) by clinic personnel under the direction of a physician. States must include a definition of “rural area” in their State plans. This definition must be either a definition adopted and used by a Federal governmental agency for programmatic purposes, or a definition adopted by a State governmental agency with a role in setting State rural health policy.

The amendments under CMS-1809-FC provide the authority for States to amend their state plans and add additional coverage outside of the clinic to the optional clinic benefit. We have developed and attached a new state plan template to simplify the SPA development, submission, and review/approval processes for states and CMS.

The completion of the template is mandatory only for states that both cover the clinic services benefit and cover tribal clinics to allow clinic services to be provided outside of the clinic under the clinic services benefit but will be available as an option for all states who wish to use the template to amend their state plan clinic pages for general updates. States must submit their SPA no later than the end of the quarter in their effective date falls and for a January 1, 2025, effective date, a SPA must be submitted by March 31, 2025, to be compliant with the effective date of CMS-1809-FC.

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<sup>2</sup> U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), The State Medicaid Manual, Manual, (Baltimore, MD, 1985), Section 4320.

<sup>3</sup> <https://public-inspection.federalregister.gov/2024-25521.pdf>.

## **B. Description of Information Collection**

### *General Assurances*

States must select the three checkboxes to confirm they are compliant with the regulation.

### *Types of Clinic Services and Limitations in Amount, Duration, or Scope*

States must provide a description of limitations on amount duration or scope and clinic types allowable under the clinic benefit and includes checkboxes and freeform text boxes for states to communicate their state specific information.

### *Four Walls Exception*

States must select the components for the exceptions for unhoused, Indian Health Service or by a Tribe or Tribal organization (unless this is not applicable in the state), and optionally, components for the exceptions for behavioral health clinics and clinics located in rural areas, and provide the definition of a rural area that applies to the exception through checkbox selection and narrative description through a freeform text box.

### *Additional Benefit Description*

A freeform text field is provided for states to use to communicate with CMS any additional relevant information related to the submission.

The template will be disseminated by CMS to States through multiple avenues:

- announced through a Medicaid.gov email blast, which will include a link to the location of the downloadable version the 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 is 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 CMS' 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 SPAs are publicly posted to [Medicad.gov](#). In accordance with § 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 calendar 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](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](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 Colombia, American Samoa, Commonwealth of the Mariana Islands, Guam, Puerto Rico, and the US Virgin Islands. In aggregate, we estimate 56 respondents.

We estimate it will take a Business Operations Specialist 22 hours at \$84.66/hr to include the time to prepare an initial SPA or occasional updates to the SPA, 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 \$124.36/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 \$125,193 [(22 hr x \$84.66/hr x 56 states) + (3 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 1400-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 (\$)
Supplement/ Attachment 3.1 Clinic	56 States	56	25	1,400	Varies	\$125,193

#### *Information Collection Instruments and Instruction/Guidance Documents*

Instructions for their completion are provided on the form. The template is a fillable form PDF.

The template is labeled “Supplement to Attachment” or “Attachment” 3.1 indicating where it is located in the state plan (labeling of these pages varies by state and benefit) and consists of the following four sections for states to complete:

- General Assurances (mandatory);
- Types of Clinic Services and Limitations in Amount, Duration, or Scope (mandatory);
- Four Walls Exceptions (mandatory); and
- Additional Benefit Description (optional).

#### **E. Timeline**

The 14-day notice published in the Federal Register on January 16, 2025 (90 FR 4744). Comments are due on/by January 30.

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, 2025, for a January 1, 2025, effective date. States will need adequate time to complete and vet these documents.