

Understanding the State Plan Amendment Process

Federal Medicaid law sets broad requirements for the program and mandates coverage of some populations and benefits while leaving many optional. States, then, make the many operational and policy decisions that determine who is eligible for enrollment, which services are covered, and how payments are set.

Each state specifies the nature and scope of its Medicaid program through the state plan. This comprehensive document must be approved by the Centers for Medicare & Medicaid Services, operating under authority delegated by the Secretary of the U.S. Department of Health and Human Services, in order for the state to access federal Medicaid funds. The state plan can be amended as needed to reflect changes in state policy and federal law and regulation.

State Plan Amendment (SPA) Process¹

State Proposes Amendment

CMS Decides <u>or</u> Requests More Info From State

State Amendment Approved

When a state proposes an amendment to its state plan, it sends the revisions to the Centers for Medicare and Medicaid Services (CMS) for review.

CMS has 90 days to make a decision, otherwise the proposed change automatically goes into effect. However, the federal government can "stop the clock" by writing to request additional information. Once the state submits the required information, a new 90-day clock begins; however, CMS may stop the clock only once per SPA.

Once approved, copies of each state plan page, including the approval date and effective date, are retained by the state and CMS. Changes can take effect retroactively to the first day of the quarter in which the state submitted the amendment. Once approved, a SPA does not expire.

Adapted from the Medicaid and CHIP Payment and Access Commission https://www.macpac.gov/subtopic/state-plan/