

Generic Supporting Statement
Medicaid Prior Authorization Assurances SPA Template
CMS-10398 #102, OMB 0938-1148

This September/October 2026 iteration is being submitted to OMB as a new generic collection of information request.

The contents of this Supporting Statement and the associated attachments have been reviewed to ensure that they are consistent with the Trump administration's policies, goals, and objectives.

A. Background

The Centers for Medicare & Medicaid Services (CMS) works in partnership with States to implement Medicaid and 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 comply with new statutory provisions. CMS also continues to work with States through other methods, including program waivers and demonstrations, and other technical assistance initiatives.

On January 17, 2024, the Centers for Medicare & Medicaid Services (CMS) released the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) to improve health information exchange and streamline prior authorization processes that involve state Medicaid fee-for-service (FFS) programs. Among the key provisions, the final rule established Medicaid regulations at 42 CFR 440.230(e) and 431.80(a) to introduce decision timeframes for prior authorization requests and how State Medicaid agencies must notify providers of those decisions.^{1,2} The timeframes and provider notice requirements apply to prior authorization requests for items and services (excluding drugs) received by the state on or after January 1, 2026.

The amendments to regulation provide the authority for State plan amendments (SPAs) to collect assurances from states regarding the operation of state Medicaid programs. The attached

¹ Per 42 CFR 440.230(e) For prior authorization requests for items and services (excluding drugs, as defined in § 431.60(b)(6) of this chapter), the State Medicaid agency must—(1) Beginning January 1, 2026, make prior authorization decisions within the following timeframes: (i) For a standard determination, as expeditiously as a beneficiary's health condition requires, but in no case later than 7 calendar days after receiving the request, unless a shorter minimum timeframe is established under State law. The timeframe for standard authorization decisions can be extended by up to 14 calendar days if the beneficiary or provider requests an extension, or if the State agency determines that additional information from the provider is needed to make a decision. (ii) For an expedited determination, as expeditiously as a beneficiary's health condition requires, but in no case later than 72 hours after receiving the request, unless a shorter minimum timeframe is established under State law.

² Per 42 CFR 431.80(a) Communicating a reason for denial. Beginning January 1, 2026, if the State denies a prior authorization request (excluding a request for coverage of drugs as defined in § 431.60(b)(6)), in accordance with the timeframes established in § 440.230(e)(1), the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information.

template has been developed to simplify the SPA submission to add these assurances to their state plan.

States should utilize and submit the template no later than the end of the quarter in which the template is released.

B. Description of Information Collection

The SPA template consists of the following:

Assurances (Required)

States must select two checkboxes to confirm they are compliant with the prior authorization requirements as described regulations at § 440.230. The content of the checkboxes is listed in the bullets below.

- Prior authorization decisions are made within the timeframes for standard and expedited determinations in accordance with § 440.230(e)(1). Beginning January 1, 2026, make prior authorization decisions within the following timeframes:
 - For a standard determination, as expeditiously as a beneficiary's health condition requires, but in no case later than 7 calendar days after receiving the request, unless a shorter timeframe is established by the state. The timeframe can be extended by up to 14 calendar days if the beneficiary or provider requests an extension, or if the State agency determines that additional information from the provider is needed to make a decision.
 - For an expedited determination, as expeditiously as a beneficiary's health condition requires, but in no case later than 72 hours after receiving the request, unless a shorter timeframe is established by the state.
 - In accordance with § 440.80(a) when a prior authorization request subject to the timeframes established in § 440.230(e)(1) is denied, the response to the provider must be communicated within applicable timeframes and include a specific reason for the denial, regardless of the method used to communicate that information.
- The state annually posts on its website the prior authorization metrics described in § 440.230(e)(3). The state makes the previous calendar year metrics publicly accessible by March 31 of each year.

Additional Information (Optional)

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

Availability of the template will be 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 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 the Division of Benefits and Coverage.

Approved SPAs are publicly posted to Medicaid.gov. In accordance with § 430.20, the effective date of a SPA, generally, may be no earlier than the first day of the quarter in which it was submitted (with the exception of 1915(i) SPAs which must be approved with a prospective effective date). However, in accordance with § 430.20(b)(3), for state plan amendments which are not related to additional services under the approved plan, payment for services, or eligibility for services, the effective date may be a date requested by the State if CMS approves it. CMS review time can vary, based on any revisions needed by the state. Generally, once they are submitted, CMS has 90 days to review and approve or disapprove a submission or respond with a formal Request for Additional Information (RAI). State responses to the RAI are requested to be sent to CMS within 90 days of receipt of the RAI. 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.

There are no plans to publish the reported information for statistical use.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

Wage Data

To derive average costs, we are using data from the U.S. Bureau of Labor Statistics' May 2025 National Occupational Employment and Wage Statistics for all salary estimates (<https://www.bls.gov/oes/tables.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 2025 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, All Other	13-1199	45.18	45.18	90.36
General and Operations Manager	11-1021	64.87	64.87	129.74

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

We estimate a potential of 56 Medicaid respondents consisting of 50 States, the District of Columbia, American Samoa, Commonwealth of the Mariana Islands, Guam, Puerto Rico, and the US Virgin Islands.

We estimate it will take a Business Operations Specialist 2 hours at \$90.36/hr to prepare an initial SPA and potentially make periodic amendments to their SPA pages. We also estimate that it will take a General and Operations Manager 3 hours at \$129.74/hr to review and approve the SPA for submission to CMS.

In aggregate we estimate a one-time state burden of 280 hours (56 states x 5 hr/response) at a cost of \$31,917 [(2 hr x \$90.36/hr x 56 states) + (3 hr x \$129.74/hr x 56 states)].

Since we have no reliable basis for estimating the number of template amendments we may receive each year, the 280-hour estimate is an annual figure that addresses the initial one-time burden at the beginning of this 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 on-going estimates 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 (\$)
Prior Authorization Assurances SPA Template	56 States	56	5	280	varies	31,917

Information Collection Instruments and Instruction Documents

- Medicaid Prior Authorization Assurances SPA Template (New)

E. Timeline

Our 14-day notice published in the Federal Register on September 25, 2026 (91 FR 60959). Comments must be received by October 9, 2026.

CMS hopes to deploy this collection within 30 - 45 days from our submission to OMB. These Medicaid state plan documents are essential for States implementing the new prior authorization timeframes and should be available as soon as possible. States will need adequate time to complete and vet these documents.