PRIOR AUTHORIZATION METRICS REPORTING – OVERVIEW & TEMPLATE

To comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization final rule, starting in 2026 impacted payers — Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs) — must publicly report certain prior authorization metrics from the previous calendar year on their websites.

While not required, we encourage payers to present metrics in a clear, visual format, such as bar charts or pie charts. We highly recommend reporting both counts and percentages so the public can understand the scope of requests. An example is included in the template below.

Metrics to be publicly reported on an impacted payer's website:

- A list of all medical items and services that require prior authorization (**excluding** drugs).
- For standard prior authorization requests, aggregated for all items and services:
  1. Percentage approved in the calendar year
  2. Percentage denied in the calendar year
  3. Percentage approved in the calendar year after appeal
     Note: This should be a subset of the total number of standard prior authorization requests appealed.
  4. The average (mean) and median response times that elapsed between the submission of a request and a determination by the payer
     Note: This should be measured from the time the payer receives the request, not when it is sent by the provider.
- For expedited prior authorization requests, aggregated for all items and services:
  1. Percentage approved in the calendar year
  2. Percentage denied in the calendar year
  3. Percentage approved in the calendar year after appeal
     Note: This is an **optional** metric and should be a subset of the total number of expedited prior authorization requests appealed.
  4. The average (mean) and median response times that elapsed between the submission of a request and a determination by the payer
     Note: This should be measured from the time the payer receives the request, not when it is sent by the provider.
- The percentage of requests where the timeframe for review was extended, per programmatic rules,[1] and the request was approved.
  Note: Though such a breakout is **optional**, CMS highly recommends differentiating between standard requests that were extended and approved and expedited requests that were extended and approved.

Note: We provide recommended denominators for these metrics in the template below.

Reporting levels:

- Metrics should be reported separately for each line of business:
  - MA organizations: report at the MA contract level
  - State Medicaid and CHIP FFS programs: report at the state level
  - Medicaid managed care plans and CHIP managed care entities: report at the plan level
  - QHP issuers on FFEs: report at the issuer level

Additional resources on prior authorization reporting requirements can be found here.

Reporting format:

While the below template is not required, we encourage payers to present data visually. Should impacted payers choose to use this template, they should replace the sample data with their own data before posting to their websites.

REFERENCES

1. For MA plans, per 42 CFR 422.568(b)(2) and 42 CFR 422.572(b), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For applicable integrated plans, per 42 CFR 422.631(d)(2)(ii), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For state Medicaid FFS programs, per 42 CFR 440.230(e)(1)(i), beginning in 2026, standard requests may be extended for up to 14 days under certain circumstances.

   For Medicaid managed care plans, per 42 CFR 438.210(d), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For state CHIP FFS programs, per 42 CFR 457.495(d), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For CHIP managed care entities, per 42 CFR 457.1230(d), standard and expedited requests may be extended for up to 14 days under certain circumstances.

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To comply with the CMS Interoperability and Prior Authorization final rule, [Enter Organization Name] is required to annually report aggregated prior authorization metrics on our website. Specifically, this includes a list of all medical items and services (excluding drugs) that require prior authorization, as well as data on prior authorization requests for those items and services (e.g., approvals, denials, etc.) over the previous calendar year. Publicly reporting these metrics promotes transparency and accountability, helps patients understand prior authorization processes, and enables providers to evaluate payer performance. In addition, metrics can be used to compare plans, programs, and payers. For questions on the data below, contact: [enter contact information].

Reporting Period: [Enter reporting year]

These are the medical items and services for which we require prior authorization (excluding drugs)

Insert a list of, or link to, all medical items and services that require prior authorization (excluding drugs)

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframes:

- For MA plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For state CHIP FFS programs, 14 days for **standard requests** (non-urgent)
- For Medicaid managed care plans and CHIP managed care entities, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For QHP issuers on the FFEs, 72 hours for **expedited requests** (urgent) and 15 days for **standard requests** (non-urgent)

There are no Medicaid FFS program required timeframes for either type of prior authorization request prior to January 1, 2026, and there are no CHIP FFS program required decision timeframes for expedited prior authorization requests prior to January 1, 2026.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires [MA plans, state Medicaid agencies, Medicaid managed care plans, state CHIP agencies, CHIP managed care entities] to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent)
- 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	40,000	50,000	80%
Request denied	10,000	50,000	20%

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 7 days	29,500	50,000	59%
(optional) Request denied within 7 days	5,500	50,000	11%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	7,500	50,000	15%
(optional) Request denied after time for review was extended	2,500	50,000	5%

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	3,000	5,000	60%
(optional) Request denied after appeal	2,000	5,000	40%

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

	How many times this happened	Out of total requests	Percentage
Request approved			
Request denied			

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 72 hours			
(optional) Request denied within 72 hours			

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*			
(optional) Request denied after time for review was extended			

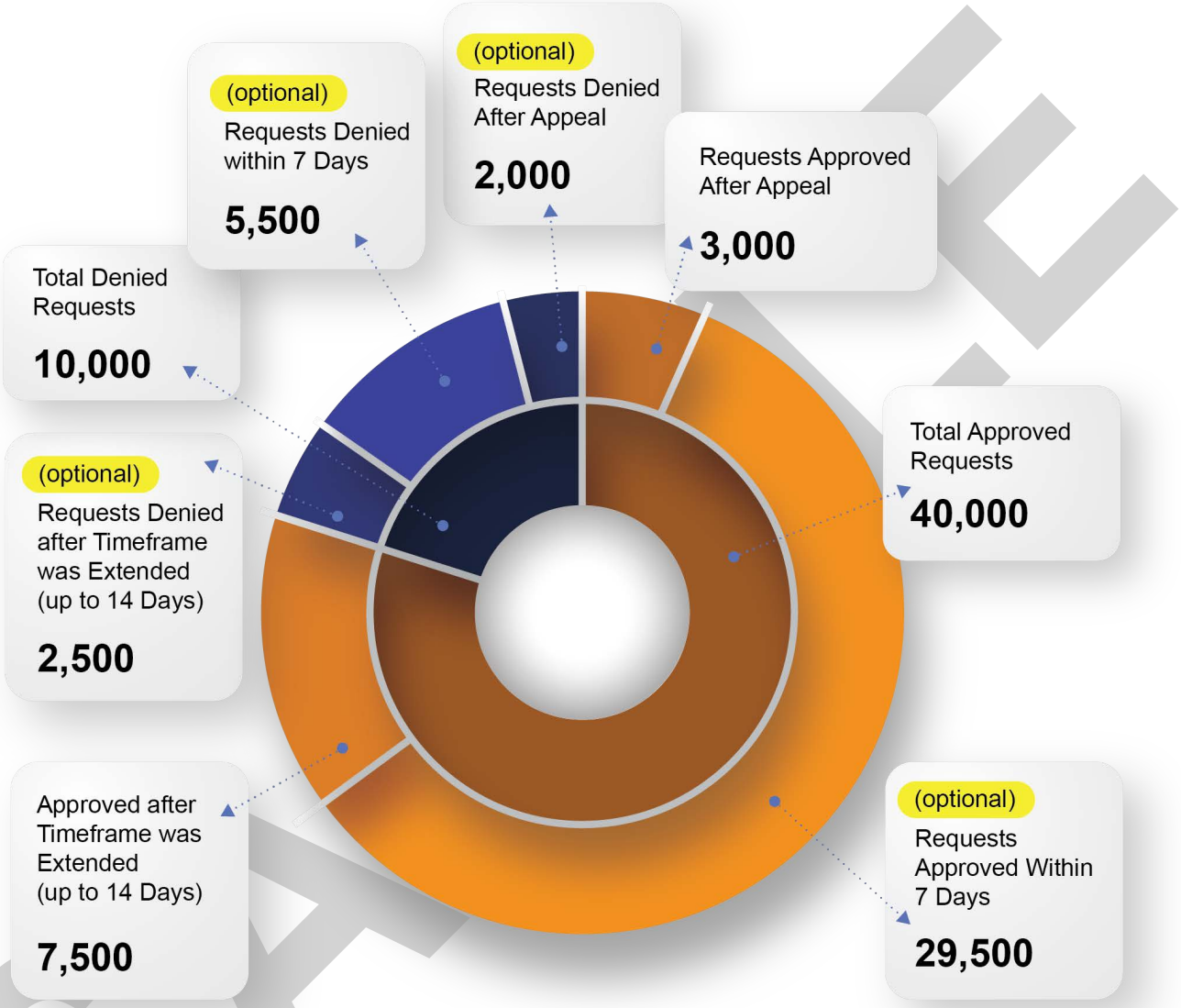
*As noted on the first page of this template, it is **optional** to report this metric separately for standard prior authorizations and expedited prior authorizations.

	How many times this happened	Out of total appeals	Percentage
(optional) Request approved only after appeal			
(optional) Request denied after appeal			

Time Between Receiving a Prior Authorization Request and Sending a Decision

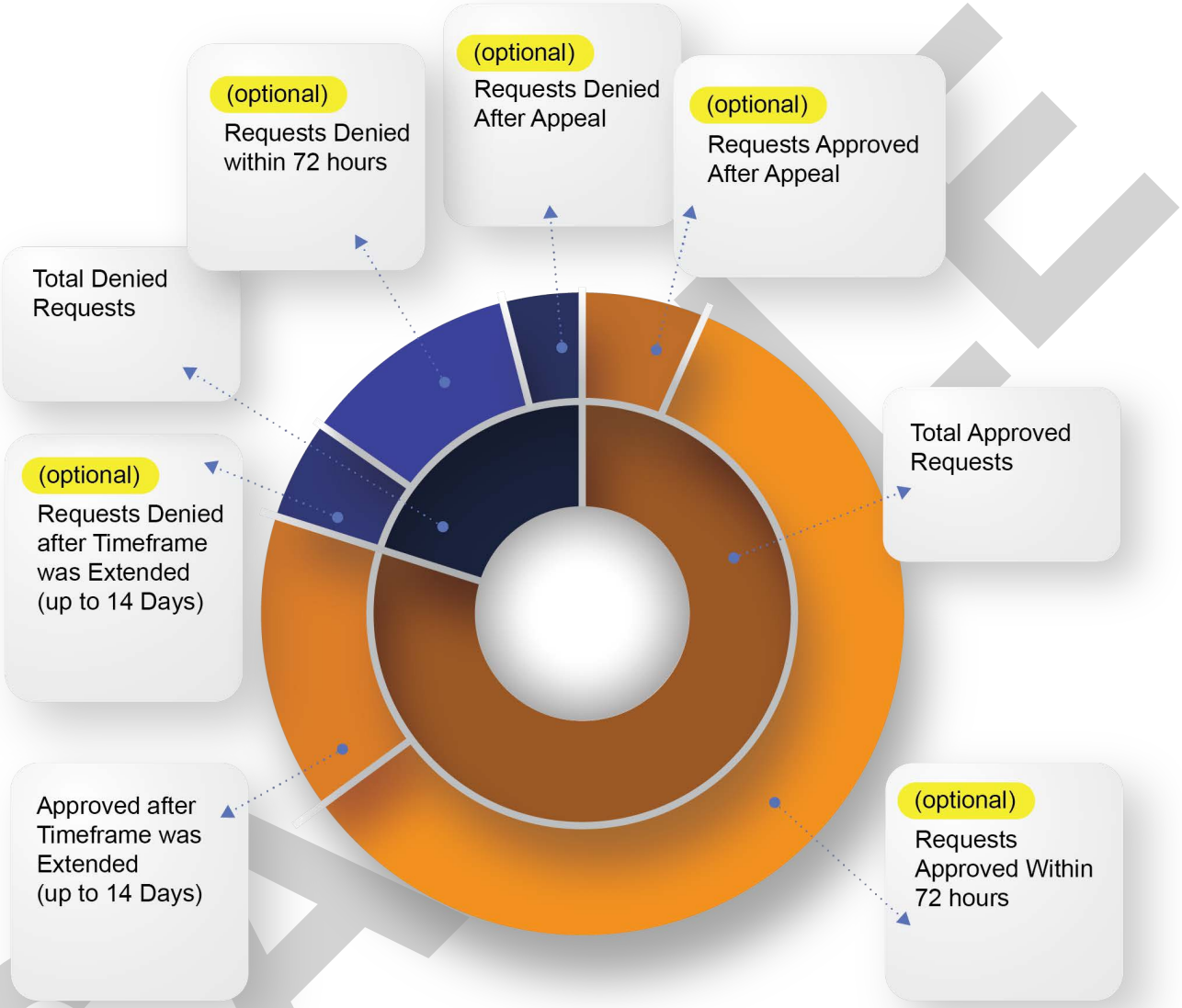
	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 7 calendar days)	5 days	4 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	1 day	1 day

In 2024, we received a total of 50,000 standard (non-urgent) prior authorization requests for our covered patients. 80% of those requests were approved:



The mean (average) time that it took to make standard prior authorization decisions was	**5 days**
The median (middle) time that it took to make standard prior authorization decisions was	**4 days**

In YEAR, we received a total of XXXXX expedited (urgent) prior authorization requests for our covered patients. XX% of those requests were approved:



The mean (average) time that it took to make expedited prior authorization decisions was	X day(s)
The median (middle) time that it took to make expedited prior authorization decisions was	X day(s)