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
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     Note: This is an **optional** metric and should be a subset of the total number of expedited prior authorization requests appealed.
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- 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.

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			

State Health Planning and Development Agency
1177 Alakea St. #402 Honolulu, Hawaii 96813
Phone: 808-587-0788 Fax: 808-587-0783 Web: https://health.hawaii.gov/shpda

Form-#: Sample

Reporting Periord: January 1 to December 31, 2025

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:	ABC Health Plan	Report date:	1/6/2026
Name of Insurer:	XYZ Health Insurance Company		
Address of Insurer:	1234 Street Name, City, Zip Code		
Leadership of Insurer:	Name/Title (e.g. President, CEO, CFO, etc.)	Phone:	(808)-123-4567 (Point of Contact)
Completed by: (name)	Name	Fax:	(808)-100-2000
(title)	Title	Email:	Email (Point of Contact)

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approved (B)	Denied (C)	Withdrawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests	50000	40000	10000	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)	35000	29500	5500	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
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						09=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)	10000	7500	2500	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
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(Response Due to Provider Within 72 Hours)

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

The sum of these two numbers is necessary for calculating the Mean Time and the Median Time. The sum can be entered into SHPDA report form Line 2 Column A.

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Form-#: Sample

Reporting Period: January 1 to December 31, 2025

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:	ABC Health Plan	Report date:	1/6/2026
Name of Insurer:	XYZ Health Insurance Company		
Address of Insurer:	1234 Street Name, City, Zip Code		
Leadership of Insurer:	Name/Title (e.g. President, CEO, CFO, etc.)	Phone:	(808)-123-4567 (Point of Contact)
Completed by: (name)	Name	Fax:	(808)-100-2000
(title)	Title	Email:	Email (Point of Contact)

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