

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

To comply with the CMS Interoperability and Prior Authorization final rule, Community Care Plan 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: mcrease@ccpcare.org

Reporting Period: 2025

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



[MMA/SMI Prior Authorization List](#)

[Florida Healthy Kids Prior Authorization List](#)

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

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For state Children's Health Insurance Program Fee-for-service programs, 14 days for **standard requests** (non-urgent)
- For Medicaid managed care plans and Children's Health Insurance Program managed care entities, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For Qualified Health Plans issuers on the Federally Facilitated Exchanges, 72 hours for **expedited requests** (urgent) and 15 days for **standard requests** (non-urgent)

There are no Medicaid Federally Facilitated Exchanges program required timeframes for either type of prior authorization request prior to January 1, 2026, and there are no Children's Health Insurance Program Fee-for-service 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 Community Care Plan 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	13,318	15,758	85%
Request denied	2,440	15,758	15%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	161	15,758	1%

	How many times this happened	Out of total requests	Percentage
Request approved only after appeal	39	112	34.82

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

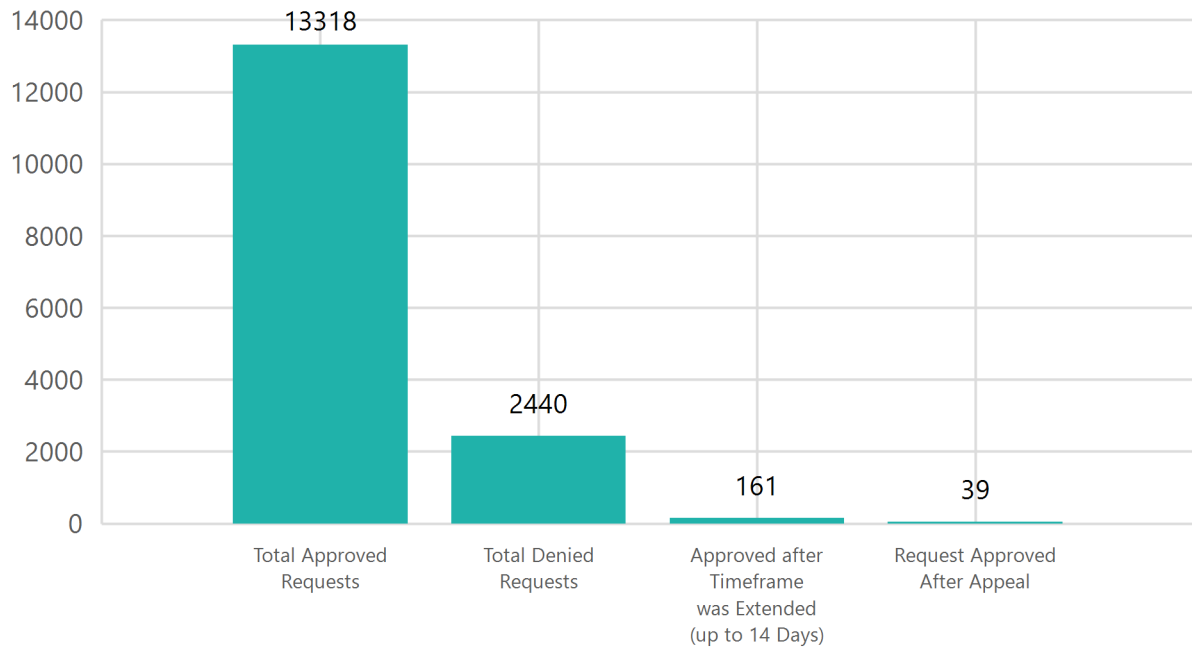
	How many times this happened	Out of total requests	Percentage
Request approved	7,486	7,625	98%
Request denied	139	7,625	2%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	348	7,625	5%

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)	2 Days	1 Day
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	1 Day	1 Day

**In 2025, we received a total of 15,758 standard (non-urgent) prior authorization requests for our covered patients.
85% of those requests were approved:**



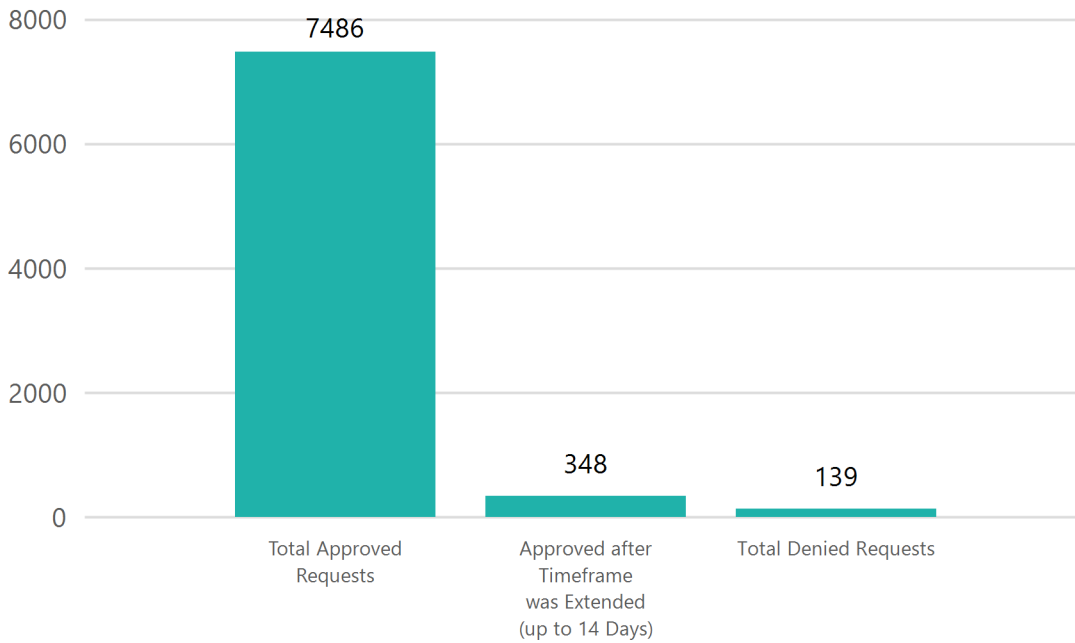
The mean (average) time that it took to make expedited prior authorization decisions was

2 Days

The median (middle) time that it took to make standard prior authorization decisions was

1 Day

In 2025, we received a total of 7,625 expedited (urgent) prior authorization requests for our covered patients. 98% of those requests were approved:



The mean (average) time that it took to make expedited prior authorization decisions was

1 Day

The median (middle) time that it took to make standard prior authorization decisions was

1 Day