

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

To comply with the CMS Interoperability and Prior Authorization final rule, Valley Area Agency on Aging 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: 810-239-7671.

Reporting Period: October 1, 2024, through September 30, 2025

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

Adult Day Health, Chore Services, Community Health Worker, Community Living Supports, Community Transportation, Counseling, Environmental Accessibility Adaptions, Fiscal Intermediary, Goods and Services, Home Delivered Meals, Nursing Services, Personal Emergency Response System, Private Duty Nursing/Respiratory Care, Respite, Specialized Medical Equipment and Supplies, Supports Coordination.

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 the MIChoice Waiver program 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	176	188	93.62%
Request denied	12	188	6.38%

	How many times this happened	Out of total requests	Percentage
(Optional) Request approved with 7 days			
(Optional) Request denied within 7 days			

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

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	1	7	14.3%
(Optional) Request denied after appeal			

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

	How many times this happened	Out of total requests	Percentage
Request approved	18	18	100%
Request denied	0	18	0%

	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
(Optional) Request approved only after time for review was extended*			
(Optional) Request denied after time for review was extended			

	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