Medicaid Division

CCO Operations Quality Assurance

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Prior Authorization Changes Resulting from Medicaid Managed Care Regulatory Revisions

Contents

Processing timeframe for standard authorization requests and notice requirements

The Centers for Medicare and Medicaid Services (CMS) finalized the Advancing Interoperability and Improving Prior Authorization Processes Final Rule on 2/8/2024. The prior authorization policies in the final rule apply to any formal decision-making process through which impacted payers render an approval or denial determination in response to prior authorization requests based on the payer's coverage guidelines and policies before

services or items are rendered or provided. In the Interoperability and Prior Authorization proposed rule (87 FR 76286), CMS provided a comprehensive review of the work the Department of Health and Human Services conducted regarding prior authorization processes and their associated burden to identify the primary issues that needed to be addressed to alleviate the burdens of these processes on patients, providers, and payers. CMS cited studies from ONC which highlighted the burdens associated with prior authorization including difficulty determining payer-specific requirements for items and services that require prior authorization; inefficient use of provider and staff time processing prior authorization requests and information (sending and receiving) through fax, telephone, and web portals; and unpredictable wait times to receive payer decisions.

Effective January 1, 2026, CCOs are required to process standard authorization requests within 7 calendar days after receiving the request for the service or item (excludes outpatient drugs). This timeframe is reduced from the previously required 14 calendar days in effect through December 31, 2025. Covered outpatient drug authorization decisions must follow the requirements in 42 CFR 438.210(d)(3), section 1927(d)(5) of the Social Security Act, and OAR 410-141-3835.

Per 42 CFR 438.210(d)(1)(ii), standard authorization decisions may have an extension to the 7-calendar day timeframe of up to 14 additional calendar days if the enrollee or the provider requests the extension; or the CCO justifies a need for additional information and how the extension is in the member's best interest.

In addition, the final rule states CCOs must provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request. As with all policies in this final rule, this provision does not apply to prior authorization decisions for drugs. This final policy is an effort to improve the communication about denials from CCOs in response to a request for a prior authorization through existing mechanisms, such as electronic portals, telephone calls, email, standard transactions, or other means.

CCOs to publicly report prior authorization metrics

Beginning January 1, 2026, CCOs must publicly report prior authorization data, excluding data on any and all drugs covered by the CCO, for the previous calendar year by posting on the CCOs' website. CCOs must post the following on their public websites by March 31 annually.

- A list of all items and services that require prior authorization.
- The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
- The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.

- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a determination by the CCO for standard prior authorizations, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a decision by the CCO for expedited prior authorizations, aggregated for all items and services.

This change is required by 42 CFR 438.210(f) and CCO Contract Ex. B, Pt. 2, Sec. 3, Para. c.

The final rule underscores the importance of transparency and accountability in the health care system. Public disclosure of the items and services which are subject to prior authorization, as well as organizational performance, offers useful information to providers, patients, and other interested parties. Performance data could allow for objective evaluation of the efficiency of prior authorization practices of each organization, and it enables payers to assess trends, identify areas for improvement, and work towards continuous process improvement while maintaining necessary quality checks for quality and appropriateness of care. The intended goal of publicly reporting prior authorization metrics is to help providers and patients gain insights into the CCOs' prior authorization practices and performance, and to assist CCOs in evaluating their prior authorization practices. Refer to the Managed Care Preamble to learn more about the public reporting requirements for prior authorization metrics.

OHA amended reporting for Exhibit I Grievance and Appeal System Logs to collect additional prior authorization data that will allow OHA to provide this data to CCOs. Due to the effective date of the changes (Q4 2025), OHA will provide a portion of the data for the public posting due on March 31, 2026 (see table 1). CCOs will need to supplement the OHA provided data to report all CMS required

metrics. The table below identifies the data that is required to be posted publicly, as described in 42 CFR 438.210(f). OHA will distribute the information through the CCO deliverables portal by COB 3/13/2026.

Table 1: Prior Authorization Public Reporting

Required Reporting	Reporting Instructions	Can OHA provide information?
A list of all items and services that require prior authorization	Post list of services and items, excluding covered drugs, requiring a prior authorization	OHA cannot provide this information. Each CCO must post their PA list on their website.
Percentage of standard prior authorization requests that were approved, aggregated for all items and services	Of the total standard prior authorization requests for all items and services, excluding drugs, enter the percentage that were fully approved.	OHA can provide Q2-Q4 2025 aggregated quarterly totals. CCOs will need to supplement with Q1 2025 data to calculate the CY percentage.
Percentage of standard prior authorization requests that were denied, aggregated for all items and services	Of the total standard prior authorization requests for all items and services, excluding drugs, enter the percentage that were fully or partially denied.	OHA can provide Q2-Q4 2025 aggregated quarterly totals. CCOs will need to supplement with Q1 2025 data to calculate the CY percentage.
Percentage of standard prior authorization requests approved after appeal,	Of the total standard prior authorization requests for all items and services,	OHA can provide Q2-Q4 2025 aggregated quarterly totals. CCOs

aggregated for all items and services	excluding drugs, enter the percentage that were approved after appeal.	will need to supplement with Q1 2025 data to calculate the CY percentage.
The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.	Of the total prior authorization requests for all items and services, excluding drugs, enter the percentage of requests for which the timeframe for review was extended and the request was approved.	OHA can provide Q2-Q4 2025 aggregated quarterly totals. CCOs will need to supplement with Q1 2025 data to calculate the CY percentage.
The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.	Of the total expedited prior authorization requests for all items and services, excluding drugs, enter the percentage that were approved.	OHA can provide Q2-Q4 2025 aggregated quarterly totals. CCOs will need to supplement with Q1 2025 data to calculate the CY percentage.
The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.	Of the total expedited prior authorization requests for all items and services, excluding drugs, enter the percentage that were denied.	OHA can provide Q2-Q4 2025 aggregated quarterly totals. CCOs will need to supplement with Q1 2025 data to calculate the CY percentage.

The average time that elapsed between the submission of a request and a determination by the CCO for standard prior authorizations, aggregated for all items and services.	Of the total standard prior authorization requests for all items and services, excluding drugs, enter the average number of days that elapsed between submission of request and decision by the CCO.	OHA cannot provide this data for the 2025 reporting due March 31, 2026.
The median time that elapsed between the submission of a request and a determination by the CCO for standard prior authorizations, aggregated for all items and services.	Of the total standard prior authorization requests for all items and services, excluding drugs, enter the median number of days that elapsed between submission of request and decision by the CCO.	OHA cannot provide this data for the 2025 reporting due March 31, 2026.
The average time that elapsed between the submission of a request and a decision by the CCO for expedited prior authorizations, aggregated for all items and services.	Of the total expedited prior authorization requests for all items and services, excluding drugs, enter the average number of hours that elapsed between submission of request and decision by the plan.	OHA cannot provide this data for the 2025 reporting due March 31, 2026.
The median time that elapsed between the submission of a request and a decision by the CCO	Of the total expedited prior authorization requests for all items and services, excluding	OHA cannot provide this data for the 2025 reporting due March 31, 2026.

for expedited prior authorizations, aggregated for all items and services.	drugs, enter the median number of hours that elapsed between submission of request and decision by the plan.	

After March 31, 2026, OHA will complete a review of the CCOs' websites to ensure the information in Table 1 is publicly posted.

Questions?

If you have any questions about this announcement, please email the CCO Quality Assurance Team at HSD.QualityAssurance@odhsoha.oregon.gov

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