Magellan 2025 Prior Authorization Report

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

To comply with the CMS Interoperability and Prior Authorization final rule, Magellan Health 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: Compliance@MagellanHealth.com

Reporting Period: 2025

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

- Assertive Community Support and Treatment
- Community Brief Crisis Support
- Community Psychiatric Support and Treatment
- Crisis Intervention Follow-up
- Crisis Stabilization
- Family Functional Therapy
- Homebuilders
- Independent Living Skills Building
- Inpatient Detox Hospitalization
- Inpatient Psychiatric Hospitalization
- Multisystemic Therapy
- Parent Support and Training
- Psychiatric Support and Rehabilitation
- Short-Term Respite
- Substance Use Intensive Outpatient
- Transcranial Magnetic Stimulation Treatment
- Wraparound
- Youth Support and Training

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	38,733	38,979	99.37%
Request denied	246	38,979	0.63%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	0	38,979	0%

	How many times this happened	Out of total requests	Percentage
Request approved only after appeal	0	38,979	0%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

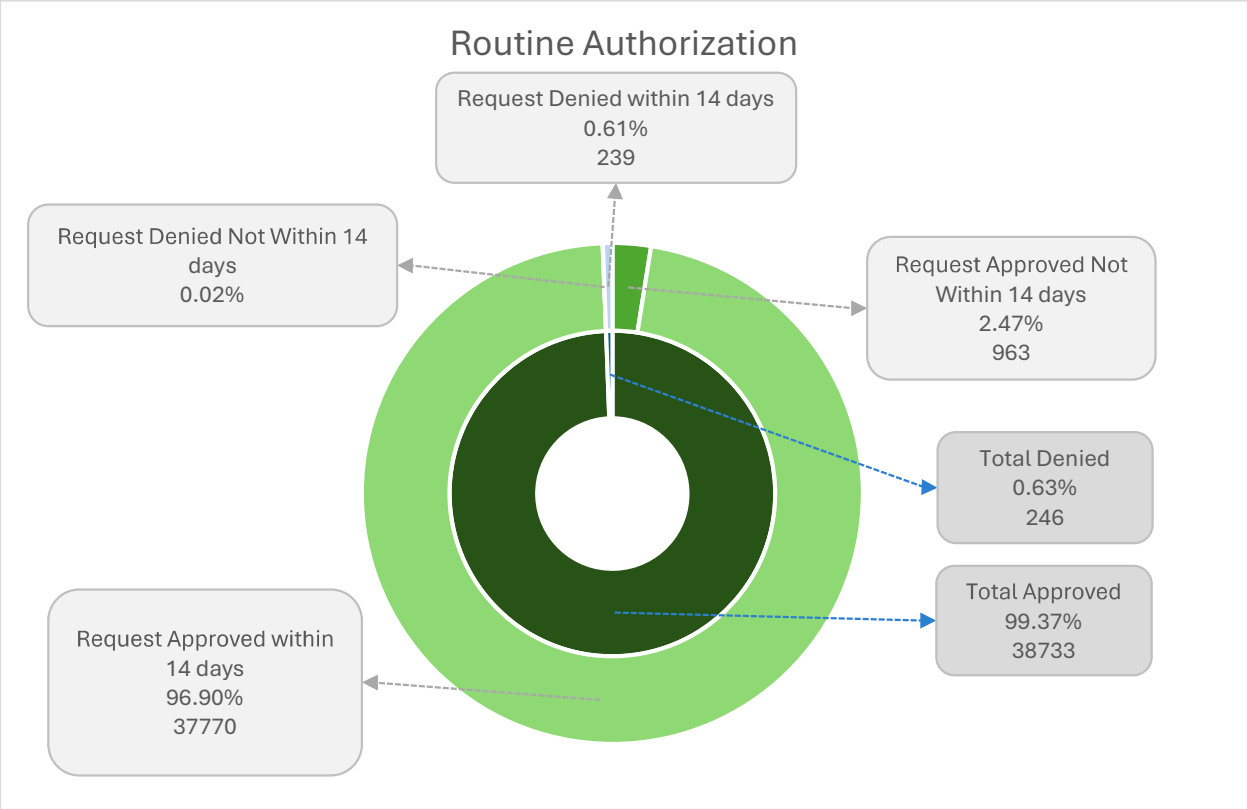
	How many times this happened	Out of total requests	Percentage
Request approved	2,868	3,490	82.18%
Request denied	622	3,490	17.82%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	0	3,490	0.00%

Time Between Receiving a Prior Authorization Request and Sending a Decision

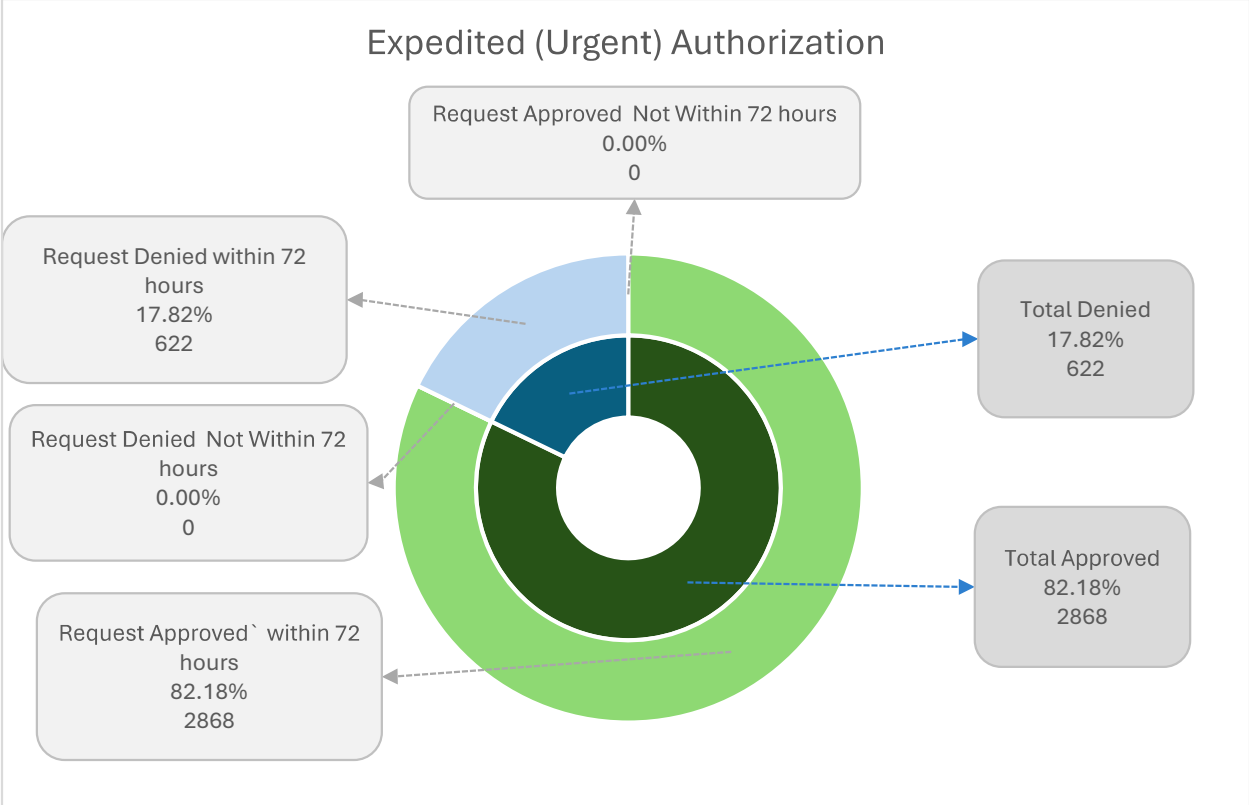
	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	7 days	8 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	2 hours	0 hours

In 2025, we received a total of 38,979 standard (non-urgent) prior authorization requests for our covered patients. 99.37% of those requests were approved:



The mean (average) time that it took to make standard prior authorization decisions was	**8 days**
The median (middle) time that it took to make standard prior authorization decisions was	**9 days**

In 2025 we received a total of 3,490 expedited (urgent) prior authorization requests for our covered patients. 82.18% of those requests were approved:



The mean (average) time that it took to make expedited prior authorization decisions was	**2 hours**
The median (middle) time that it took to make expedited prior authorization decisions was	**0 hours**