ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Prior Authorization Metrics for Medical Items and Services (Excluding Drugs)

Date: March 31, 2026

Prior Authorization Metrics for Medical Items and Services (Excluding Drugs)

To comply with the CMS Interoperability and Prior Authorization final rule, the Arizona Health Care Cost Containment System (AHCCCS) 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 Shealee Gartner, Clinical Project Manager at shealee.gartner@azahcccs.gov.

Reporting Period: CY 2025

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

AHCCCS has outlined prior authorization requirements for all fee-for-service (FFS) populations, which includes the Tribal ALTCS program, in the AHCCCS Medical Policy Manual (AMPM 820: FFS Authorization Requirements), located here:

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/800/820.pdf

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires 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)

Prior Authorization Metrics for Medical Items and Services (Excluding Drugs)

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Total Requests Approved	107,959	111,836	96.5%
Total Requests Denied	3,877	111,836	3.5%

	How many times this happened	Out of total requests	Percentage
Total Requests Approved Only After Time for Review was Extended	19,454	20,106	97%

	How many times this happened	Out of total appeals	Percentage
Total Requests Approved Only After Appeal	32	45	71%

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

	How many times this happened	Out of total requests	Percentage
Total Requests Approved	110,794	128,549	86.2%
Total Requests Denied	17,755	128,549	13.8%

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)	7 Days	5.25 Days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	2 Days	1 Day

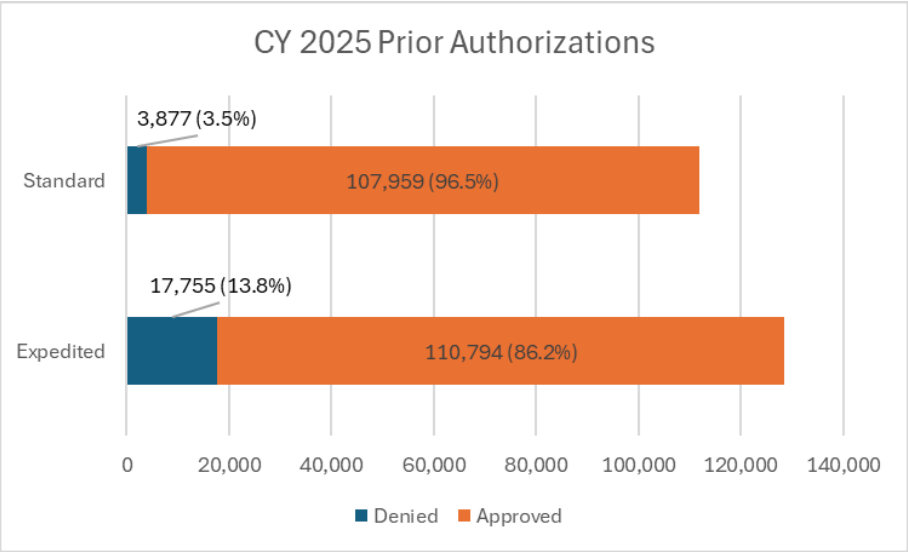
Data Methodology Limitations:

AHCCCS has identified several limitations when collecting data related to standard (non-urgent) and expedited (urgent) prior authorization requests and is working to identify solutions for future reporting. These include the following:

- A small percentage of prior authorization requests are submitted through email or fax. These requests are not included in the aggregate totals at this time. AHCCCS is working to identify processes that will allow for the timely capture and reporting of this information.
- The prior authorization request data reported above does not include prior authorization requests made to and addressed by tribal providers. AHCCCS is identifying several solutions that may allow for easy capture of prior authorization data for the Tribal ALTCS program, including developing new electronic processes to identify prior authorization requests.
- Prior authorization data for the Tribal ALTCS program is not included for several of the metrics reported, namely "Total Requests Approved Only After Time for Review was Extended" and metrics related to the reporting of expedited (urgent) prior authorization requests. For CY 2025, there were no systems or processes in place that would allow for the reporting of this data. AHCCCS is working internally and with the tribal providers to determine how best to support the capture of this information for future reporting.
- AHCCCS currently defines expedited (urgent) prior authorization requests as any requests processed within 72 hours of receipt, regardless of medical need. Under CMS' definition, expedited prior authorization requests are those processed within 72 hours to mitigate events that jeopardize a member's life, health, or ability to regain maximum function. AHCCCS is working internally to capture expedited prior authorization requests in alignment with CMS' expectations.

Prior Authorization Metrics for Medical Items and Services (Excluding Drugs)

In Calendar Year (CY) 2025, AHCCCS received a total of 111,836 standard prior authorization requests for our members. Of those standard requests, 96.5% were approved. AHCCCS received a total of 128,549 expedited prior authorization requests for members. Of those expedited requests, 86.2% were approved:



STANDARD PRIOR AUTHORIZATIONS

The mean (average) time that it took to make standard prior authorization decisions was	**7 days**
The median (middle) time that it took to make standard prior authorization decisions was	**5.25 days**

EXPEDITED PRIOR AUTHORIZATIONS

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 expedited prior authorization decisions was	**1 day**