



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

To comply with the CMS Interoperability and Prior Authorization [final rule](#), Longevity 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: utilizationmanagement@longevityhealthplan.com

Reporting Period: 2025

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



<https://longevityhealthplan.com/plan-documents/>

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 to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent)
 - 7 calendar days for **standard requests** (non-urgent)
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Standard (non-urgent) Prior Authorization Requests

STANDARD (non-urgent) Prior Authorization Requests				
		How Many Times This Happened	Out of Total Requests	Percentage
CO	Request Approved	422	491	86%
	Request Denied	69	491	14%
	Request Approved Only After Appeal	5	5	100%
FL	Request Approved	1179	1410	84%
	Request Denied	231	1410	16%
	Request Approved Only After Appeal	15	18	83%
IL	Request Approved	1799	2115	85%
	Request Denied	316	2115	15%
	Request Approved Only After Appeal	31	41	76%
MI	Request Approved	1845	2187	84%
	Request Denied	342	2187	16%
	Request Approved Only After Appeal	27	35	77%
NC	Request Approved	1895	2209	86%
	Request Denied	314	2209	14%
	Request Approved Only After Appeal	27	38	71%
NJ	Request Approved	1686	1978	85%
	Request Denied	292	1978	15%
	Request Approved Only After Appeal	17	55	31%
NY	Request Approved	906	994	91%
	Request Denied	88	994	9%
	Request Approved Only After Appeal	22	24	92%

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

EXPEDITED (urgent) Prior Authorization Requests				
		How Many Times This Happened	Out of Total Requests	Percentage
CO	Request Approved	163	180	91%
	Request Denied	17	180	9%
	Request Approved Only After Appeal	5	8	63%
FL	Request Approved	415	519	80%
	Request Denied	104	519	20%
	Request Approved Only After Appeal	10	17	59%
IL	Request Approved	539	633	85%
	Request Denied	94	633	15%
	Request Approved Only After Appeal	17	22	77%
MI	Request Approved	829	939	88%
	Request Denied	110	939	12%
	Request Approved Only After Appeal	7	14	50%
NC	Request Approved	645	734	88%
	Request Denied	89	734	12%
	Request Approved Only After Appeal	5	9	56%
NJ	Request Approved	500	586	85%
	Request Denied	86	586	15%
	Request Approved Only After Appeal	17	24	71%
NY	Request Approved	224	298	75%
	Request Denied	74	298	25%
	Request Approved Only After Appeal	3	3	100%



Time Between Receiving a Prior Authorization Request and Sending a Decision

Time Between Received a Prior Authorization Request and Sending a Decision			
		Mean (Average) Time	Median (Middle) Time
CO	Standard	4.5 Days	3 Days
	Expedited	2.52 Days	3 Days
FL	Standard	3.7 Days	3 Days
	Expedited	2.3 Days	3 Days
IL	Standard	3.5 Days	3 Days
	Expedited	2.4 Days	3 Days
MI	Standard	3.5 Days	3 Days
	Expedited	2.3 Days	3 Days
NC	Standard	3.8 Days	3 Days
	Expedited	2.2 Days	3 Days
NJ	Standard	3.7 Days	3 Days
	Expedited	2.7 Days	3 Days
NY	Standard	3.1 Days	3 Days
	Expedited	2.3 Days	3 Days

Longevity Health Plan Inc. is an HMO I-SNP with a Medicare contract. Longevity Health Plan of New Jersey Inc. is a PPO I-SNP with a Medicare contract. Enrollment in Longevity Health Plan depends on contract renewal. Longevity Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.