



## CMS Interoperability Prior Authorization Metric for the Align DUALPartnership Plan (HMO D-SNP) and Great Plains Medicare Advantage H8967 Plans

To comply with the CMS Interoperability and Prior Authorization **final rule**, Sanford Health Plan 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 Align DUALPartnership, Customer Service: **(877) 509-4979** or Great Plains Medicare Advantage Customer Service: **(877) 492-5189**.

**Reporting Period:** 2025

### **Great Plains Medicare Advantage Coded Prior Authorization List**

### **Align DUALPartnership Coded Prior Authorization List**

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.

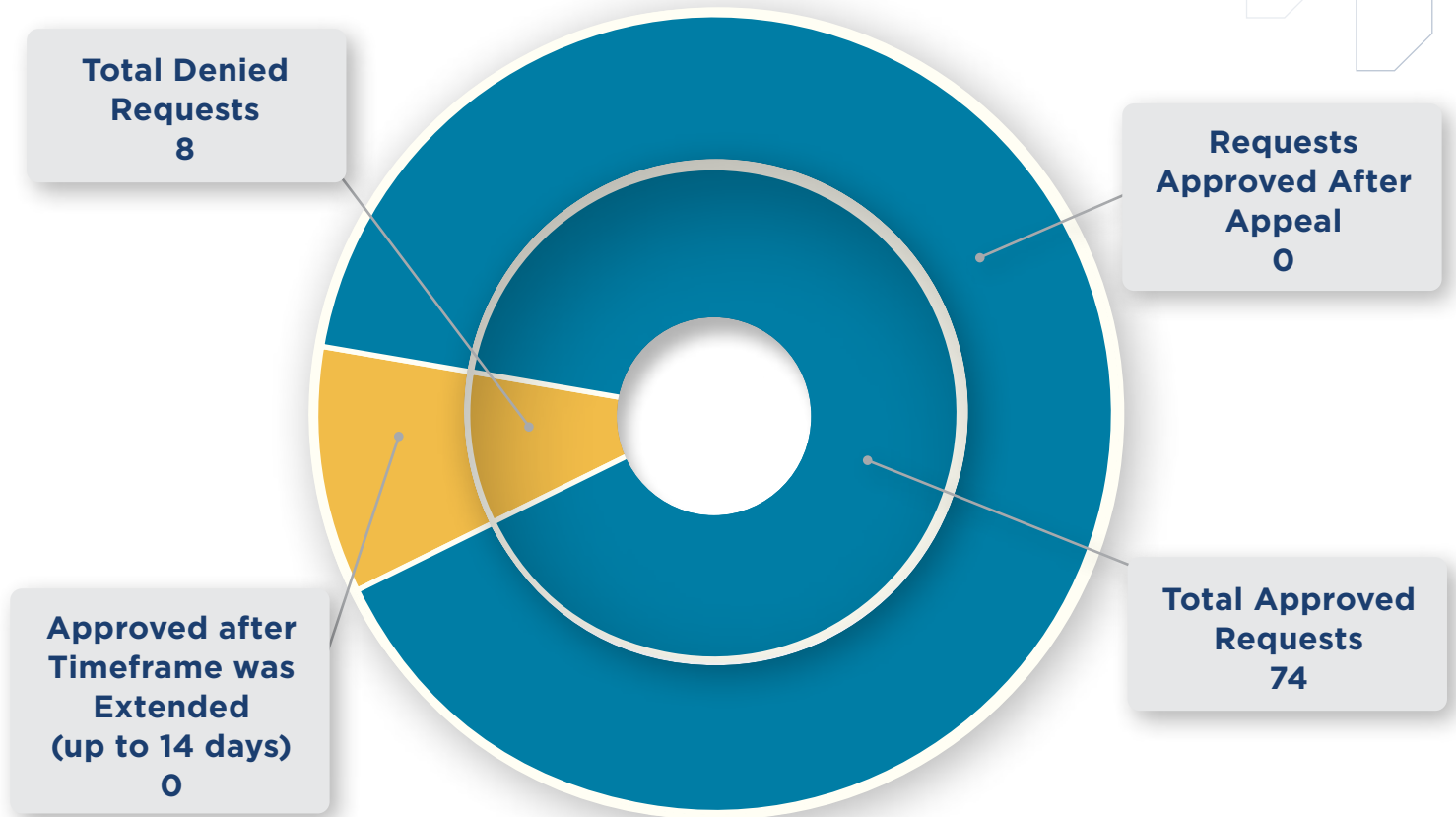
Beginning January 1, 2026, the CMS Interoperability and Prior Authorization **final rule** requires Medicare Advantage (MA) Organizations to send prior authorization decisions within:

- 72 hours for expedited requests (urgent)
- 7 calendar days for standard requests (non-urgent)

## Standard (non-urgent) Prior Authorization Requests

In 2025, we received a total of 82 standard (non-urgent) prior authorization requests for our covered patients. 90.2% of those requests were approved:

### Standard Authorizations



The mean (average) time that it took to make standard prior authorization decisions was

**0.7 day(s)**

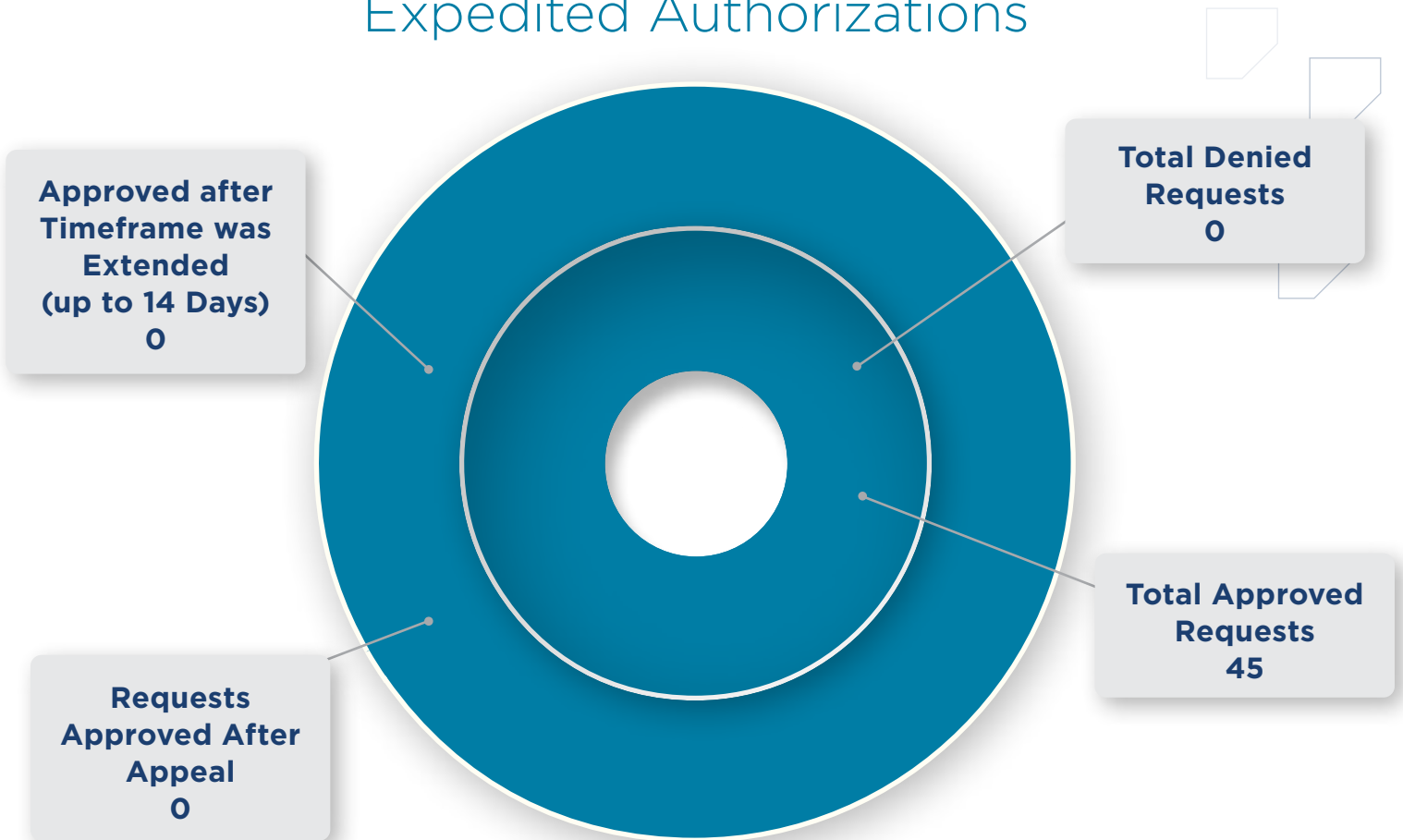
The median (middle) time that it took to make standard prior authorization decisions was

**0 day(s)**

## Expedited (urgent) Prior Authorization Requests

In 2025, we received a total of 45 expedited (urgent) prior authorization requests for our covered patients. 100% of those requests were approved:

### Expedited Authorizations



The mean (average) time that it took to make expedited prior authorization decisions was

**0.3 day(s)**

The median (middle) time that it took to make expedited prior authorization decisions was

**0 day(s)**