# CMS Interoperability Prior Authorization Metric for the Align powered by Sanford Health Plan H8385 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 Customer Service: **(877) 509-4979**.

**Reporting Period:** 2025

## 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)

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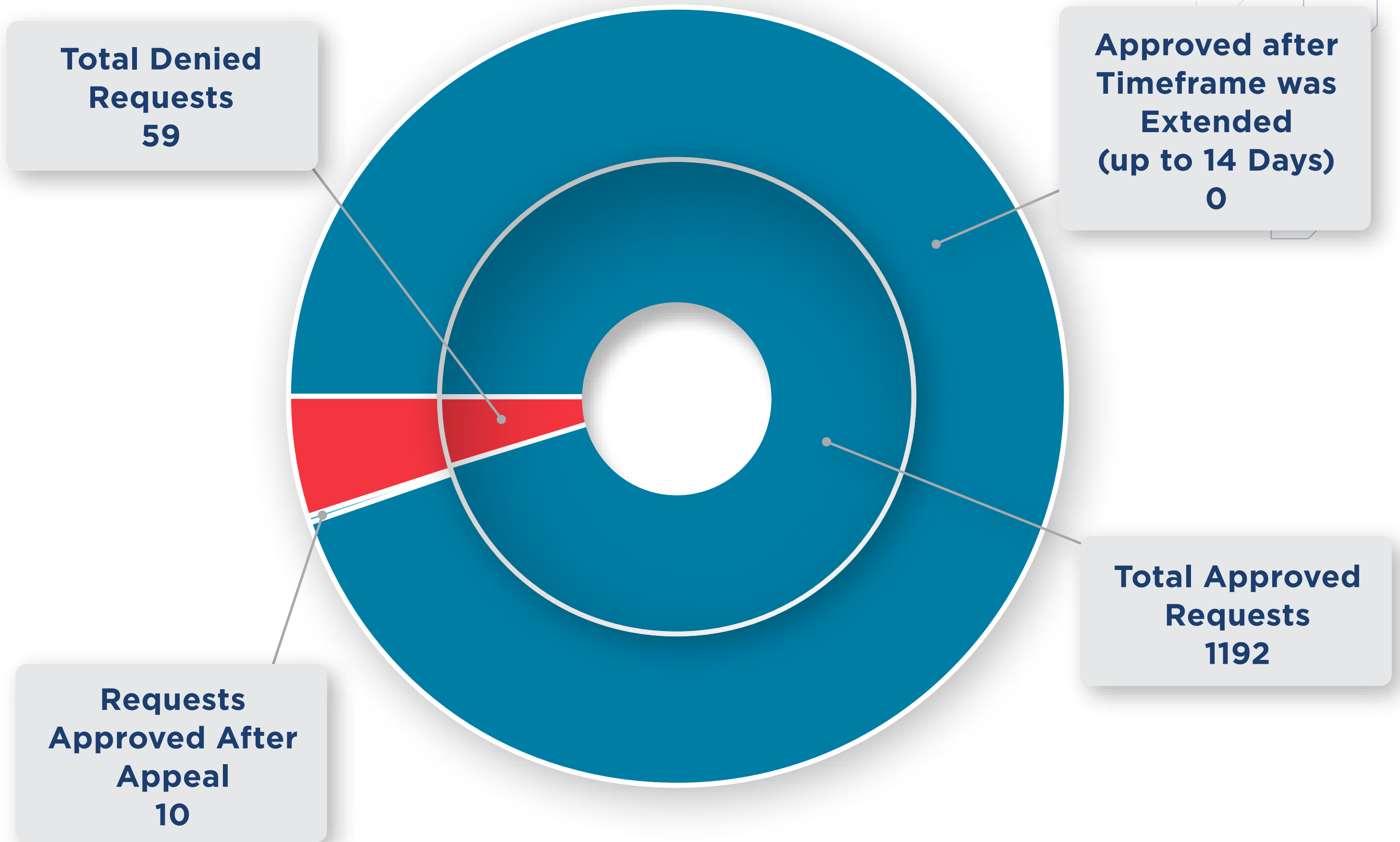
## Standard (non-urgent) Prior Authorization Requests

**In 2025, we received a total of 1,251 standard (non-urgent) prior authorization requests for our covered patients. 95.3% of those requests were approved:**




| | |
|---|---|
| The mean (average) time that it took to make standard prior authorization decisions was | **0.4 day(s)** |
| The median (middle) time that it took to make standard prior authorization decisions was | **0 day(s)** |

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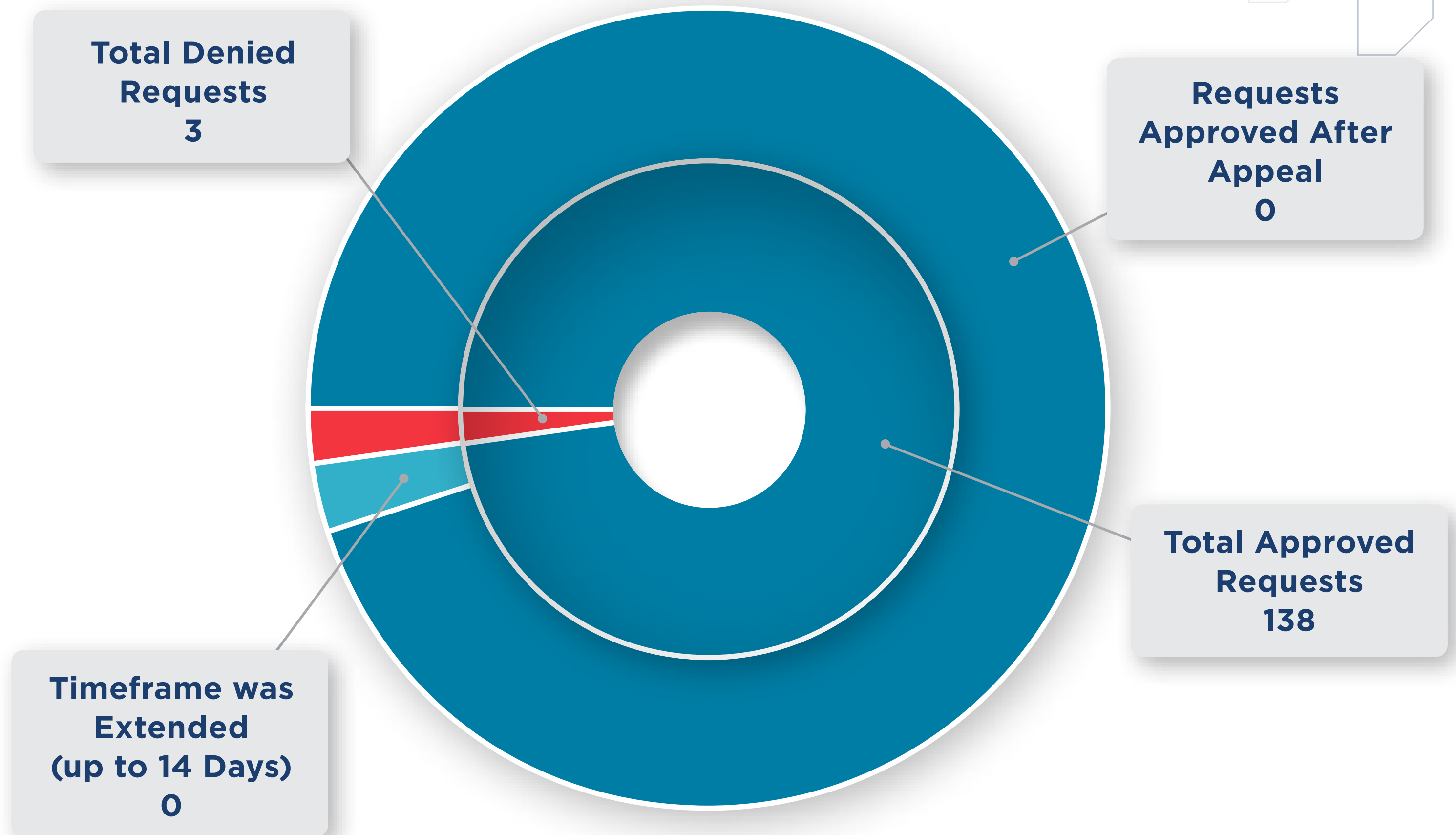
# Expedited (urgent) Prior Authorization Requests

**In 2025, we received a total of 141 expedited (urgent) prior authorization requests for our covered patients. 97.9% of those requests were approved:**

## Expedited Authorizations




| | |
|---|---|
| The mean (average) time that it took to make expedited prior authorization decisions was | **0.5 day(s)** |
| The median (middle) time that it took to make expedited prior authorization decisions was | **0 day(s)** |