UCLA Health | Medicare ADVANTAGE PLAN

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

To comply with the CMS Interoperability and Prior Authorization final rule, **UCLA Health Medicare Advantage 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:

UCLA Medicare Advantage Plan Utilization Management Department
Email: UtilizationManagement@uhmap.com
Phone: 310-301-7302
Fax: 424-234-7698

Address: 5757 W. Century Blvd Los Angeles, CA 90047

Reporting Period: 2025

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 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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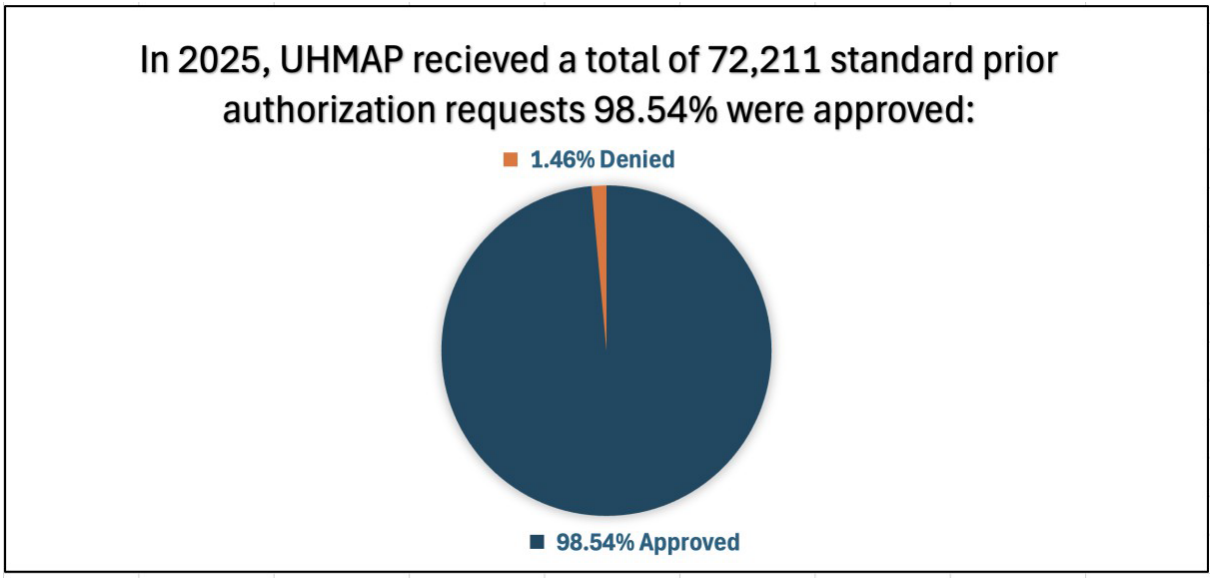
2025 UCLA HEALTH MEDICARE ADVANTAGE PLAN (UHMAP) PRIOR AUTHORIZATION REPORTING PERIOD

Standard Prior Authorization Requests



	How Many Times This Happened	Out of Total Requests	% Total
Requests Approved	72,145	73,211	**98.54%**
Requests Denied	1,066	73,211	**1.46%**

	How Many Times This Happened	Out of Total Requests	% Total
Requests Approved Only After Time for Review Was Extended	0	0	**0%**

	How Many Times This Happened	Out of Total Requests	% Total
Requests Approved only after Appeal	15	72	**21%**
Requests Denied only after Appeal	57	72	**79%**

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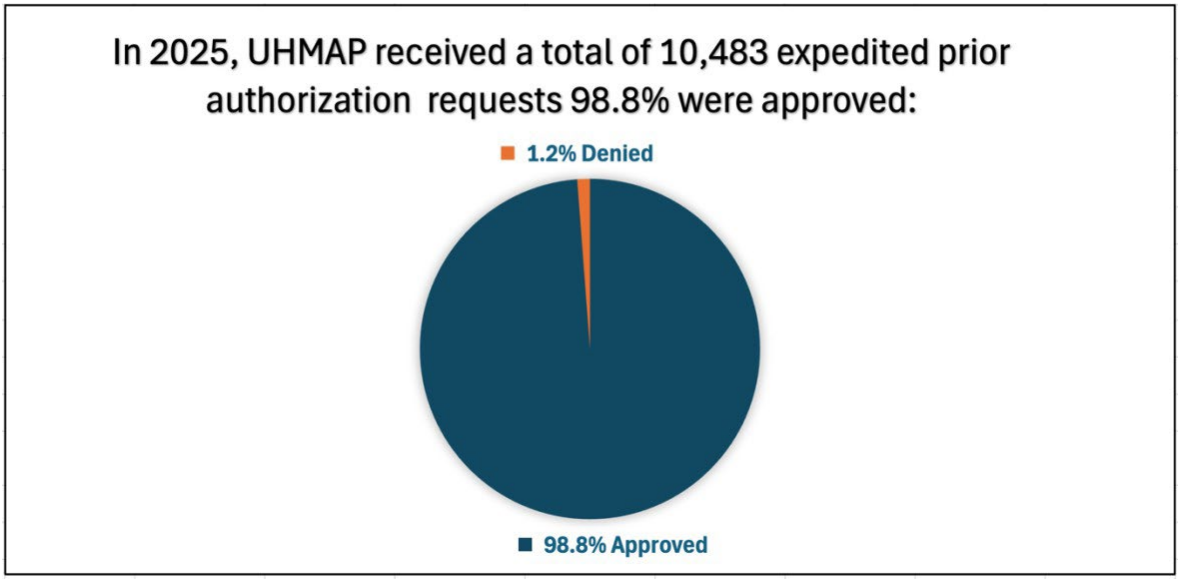
Expedited Prior Authorization Requests



	How Many Times This Happened	Out of Total Requests	% Total
Requests Approved	10,357	10,483	**98.8%**
Requests Denied	126	10,483	**1.2%**

	How Many Times This Happened	Out of Total Requests	% Total
Requests Approved Only After Time for Review Was Extended	0	0	**0%**

Time Between Receiving a Prior Authorization Request and Health Plan Determination

	Mean (Avg) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests	2.7 Days	0 Days
Expedited (urgent) Prior Authorization Requests	0.33 Days	0 Days