Annual Health Equity Analysis of Utilization Management Policies and Procedures: 2024

The Center for Medicare & Medicaid Services (CMS) issued the 2025 Final Rule for Medicare Advantage Program, Medicare Prescription Drug Benefit Program (Medicare Part D), Medicare Cost Plan Program, Programs for All-Inclusive Care for the Elderly (PACE), and Health Information Technology Standards and Implementation Specifications on April 4, 2024. The policy changes addressed in the final rule promote equity in coverage on underserved populations and promote transparency via annual reporting on the impact of utilization management policies and procedures (prior authorization) on enrollees who receive the Part D low-income subsidy, who are dually eligible, or who have a disability (§ 422.137 Medicare Advantage Utilization Management Committee).

> Beginning in 2025, the analysis must use the following metrics, calculated for enrollees with the specified social risk factors and enrollees without the specified social risk factors, to conduct the analysis at the plan level using data from the prior contract year regarding coverage of items and services excluding data on drugs as defined in § 422.119(b)(1)(v):
>
> (A) The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
> (B) The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
> (C) The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
> (D) The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
> (E) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
> (F) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
> (G) The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations, aggregated for all items and services.
> (H) The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, aggregated for all items and services aggregated for all items and services.

Standard and expedited initial prior authorization requests:

Request	All MVP Medicare Advantage		Population with No Social Risk Factors		Population with Social Risk Factors	
	Approved (%)	Denied (%)	Approved (%)	Denied (%)	Approved (%)	Denied (%)
Standard	99.7	0.3	99.79	0.21	99.44	0.56
Expedited	99.1	0.9	99.3	0.77	98.74	1.26

Standard appeal prior authorization requests:

All MVP Medicare Advantage	Population with No Social Risk Factors	Population with Social Risk Factors
Standard Appeals (% Approved)	Standard Appeals (% Approved)	Standard Appeals (% Approved)
95.24	98.33	87.5

Prior Authorization requests for which timeframe for review was extended:

All MVP Medicare Advantage	Population with No Social Risk Factors	Population with Social Risk Factors
Standard Appeals (% Approved)	Standard Appeals (% Approved)	Standard Appeals (% Approved)
99.29	100	97.3

Median and average time between request submission and determination:

Request	All MVP Medicare Advantage		Population with No Social Risk Factors		Population with Social Risk Factors	
	Median	Average	Median	Average	Median	Average
Standard	6	5.09	5	5.03	6	5.28
Expedited	0	0.91	0	0.8	0	1.2

Reviewed and approved by MVP HEI Officer

Reviewed and approved by MVP Quality Improvement Committee, May 2025