Aetna Better Health®
Premier Plan

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

To follow new federal rules, Aetna Better Health® Premier Plan (Medicare-Medicaid Plan) must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-855-676-5772 (TYY 711).

Reporting Period: 2025
Product: Medicare Medicaid Plan (MMP)
Contract: H8026 Aetna Better Health® Premier Plan (Medicare-Medicaid Plan)

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

To access the prior auth grid, please click on this link. Then click on "Search ProPat"

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires applicable integrated plans to send prior authorization decisions within:

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

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Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	94.13%
Request denied	5.87%
Request approved after appeal	33.33%

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

	Percentage
Request approved	96.19%
Request denied	3.81%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	none

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	4.15 days	2.0 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	1.61 days	1.0 days

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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