STATE OF MISSISSIPPI
GOVERNOR TATE REEVES

DEPARTMENT OF FINANCE AND ADMINISTRATION
LIZ WELCH
EXECUTIVE DIRECTOR

Pharmacy Prior Authorization Statistics

These regulations reflect 2024 MS SB 2140 and Emergency Prior Authorization rule requirements and do the following:

- Effective 3/31, and annually thereafter, requires plans to publish specified prior authorization statistics on website.
- Effective 6/1, and annually thereafter, requires plans to report specified prior authorization numbers to Department of Insurance.
- Effective 1/1:
    - Repeals the sunset provision.
    - Defines chronic condition.
    - Changes the fee for application & renewal of private review agent.
    - Outlines Utilization Review standards, including:
        - Timeframes,
        - Notification requirements,
        - Identification and contact information for licensed clinical personnel,
        - When prior authorizations may be revoked, and
        - ePA.
    - Outlines penalties for non-compliance.

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Carrier ID: 20BR	
CVS Caremark State of Mississippi	**1/1/2024 to 12/31/2024**
(7) Health insurance issuers using prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format. Following each calendar year, the statistics must be updated annually, by March 31, and include all of the following information:	
(a) A list of all health care services, including medications, that are subject to prior authorization;	https://www.dfa.ms.gov/cvs-caremark
(b) The percentage of standard prior authorization requests that were approved, aggregated for all items and services;	52.1%
(c) The percentage of standard prior authorization requests that were denied, aggregated for all items and services;	47.9%
(d) The percentage of prior authorization requests that were approved after appeal, aggregated for all items and services;	38.6%
(e) 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;	0.002%
(f) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services;	61.1%
(g) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services;	38.9%
(h) The average and median time that elapsed between the submission of a request and a determination by the payer, plan or health insurance issuer, for standard prior authorization, aggregated for all items and services;	Average: 8.1 hours Median: 35.33 hours
(i) The average and median time that elapsed between the submission of a request and a decision by the payer, plan or health insurance issuer, for expedited prior authorizations, aggregated for all items and services; and	Average: 2.2 hours Median: 17.44 hours
(j) Any other information as the department determines appropriate	Not applicable

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(d) The percentage of prior authorization requests that were approved after appeal, aggregated for all items and services;
(e) 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;
(f) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services;
(g) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services;
(h) The average and median time that elapsed between the submission of a request and a determination by the payer, plan or health insurance issuer, for standard prior authorization, aggregated for all items and services;
(i) The average and median time that elapsed between the submission of a request and a decision by the payer, plan or health insurance issuer, for expedited prior authorizations, aggregated for all items and services; and
(j) Any other information as the department determines appropriate

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MS - Title 19, Part 3, Chapter 19, Rules 19.01 through .2623- Permanent Prior Authorization Regulations
Rule 19.21. Reports to the Department
(1) By June 1, 2025, and each June 1 after that date, a health insurance issuer shall report to the department, on a form issued by the department, the following aggregated trend data, de-identified of protected health information, related to the insurer's practices and experience for the prior plan year for health care services submitted for payment:
(a) The number of prior authorization requests;
(b) The number of prior authorization requests denied;
(c) The number of prior authorization appeals received;
(d) The number of adverse determinations reversed on appeal;
(e) Of the total number of prior authorization requests, the number of prior authorization requests that were not submitted electronically;
(f) The ten (10) health care services that were most frequently denied through prior authorization;
(g) The ten (10) reasons prior authorization requests were most frequently denied;
(h) The number of claims for health care services that were examined through a post-service utilization review process;
(i) The number and percentage of claims for health care services denied through post-service utilization review; and
(j) The ten (10) health care services that were most frequently denied as a result of post-service utilization reviews.
(k) Any prior authorization requirements that have been removed.
(2) All reports required by this section shall be considered public records under the Mississippi Public Records Act of 1983 and the department shall make all reports freely available to requestors and post all reports to its public website without redactions.