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Automation in Medicaid Prior Authorization

Policy options

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Project Overview

Project Overview

Automation: the use of technological tools such as algorithms and artificial intelligence (AI) that supplement or replace human action or decision making

- **Algorithm:** A procedure or set of rules that is applied to a dataset to achieve a certain function or purpose
- **AI:** A machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments

- **Project objective:** understand how automation is being used in the Medicaid prior authorization (PA) process in the managed care and fee-for-service (FFS) delivery systems
- MACPAC and contractor conducted literature review, federal policy reviews, and stakeholder interviews

Background

Prior Authorization

The multi-step process by which health care payers require medical providers to receive approval before providing a specific item, service, or medication

- Intended to reduce costs by promoting appropriate, cost-effective care
- Some research shows that PA can reduce costs without negatively impacting care
- However, beneficiary advocates and others have raised concerns
  - PA may delay or deny needed care
  - PA increases administrative costs for providers

PA in Medicaid

- Statute and regulation give states the authority to implement PA in their FFS Medicaid programs
- Federal regulations require state managed care contracts to permit managed care plans to implement PA
  - Managed care plans must meet certain standards for timeliness, reporting, and clinical review of PA
- The Centers for Medicare & Medicaid Services (CMS) conducts oversight of FFS programs and reviews and approves states' managed care contracts
  - The Interoperability and Prior Authorization Final Rule subjects both FFS and managed care programs to additional timeliness, transparency and reporting, and Application Programming Interface (API) requirements beginning in 2026

Findings

Findings

- States and managed care plans are using AI and algorithms in Medicaid PA
  - Virtually all states and plans report they are not using automation for final clinical decision making
- States and the federal government have limited visibility into plans' use of automation in Medicaid PA
  - Existing contracting and oversight mechanisms present an opportunity to increase transparency
- Current federal policy neither prescribes nor prohibits specific uses or adoptions of automation in PA
- Some states have passed legislation regulating payers' use of automation in care decisions

Findings, cont'd.

- Some states, managed care plans, and information technology (IT) vendors have established formal AI governance structures
- Automated PA processes present potential risks to beneficiaries, states, providers, and health plans
  - Automation tools may make incorrect PA decisions
  - There is limited transparency into how automation tools make decisions
- Limited federal guidance on automation in Medicaid PA is slowing the adoption of automation tools
  - Some states, payers, providers and IT vendors spoke in support of standardized federal guidelines, however some raised concerns about federal action

Challenges

Challenges

There is limited transparency into how automated PA systems work and their impact on costs and access to care

- There is little visibility into how automation is being used, how automation tools make PA decisions, and the approval and denial rates for automated systems
- The complexity of AI-based systems can make it difficult to understand how and why PA decisions are made
- Automated PA systems may also increase adverse determination rates due to data bias or programming flaws, which may not be readily visible

Challenges

There is limited federal guidance regarding automation in PA, and state guidance varies

- Current Medicaid regulations do not directly regulate, guide, or monitor the use of automation in PA
- States and managed care plans are reluctant to implement automation in the absence of federal guidance and regulations
- Varying state approaches create a fragmented regulatory environment that is burdensome for providers, managed care plans, and IT vendors

Policy Principles

Principle 1

Automation in Medicaid PA offers administrative efficiencies for payers and providers, which can improve timeliness of approvals, beneficiary experience, and access to care

- Automation can introduce efficiencies into the PA process
  - Increase speed of approvals
  - Promote cost-effective care
  - Streamline the request and appeal process for providers
- These efficiencies present benefits to managed care plans, providers, and beneficiaries
- However, these benefits must be balanced against the risks posed by automation

Principle 2

Transparency and disclosure are important tools in documenting and assessing the use of automation, including the nature of emerging risks

- Much is unknown about the development, implementation, and impacts of automation on the Medicaid PA process
- States and the federal government collect limited data on automation in Medicaid PA
- Intellectual property protections and technical complexity further limit transparency
- Policy should reduce barriers to data and information about the use and impacts of automation in Medicaid PA

Principle 3

Due to the evolving nature of automation technologies and their increasing application, ongoing reevaluation of the oversight policy framework in Medicaid PA is warranted

- Automation technology is improving in its functionality and quickly expanding in domains such as healthcare
  - Research shows AI-based systems outperform clinicians in some diagnostic tasks
  - AI-based PA systems may provide faster and more accurate PA determinations in the future
- Policy addressing automation in Medicaid PA should be regularly reevaluated to remove obstacles to innovation and respond to new risks

Policy Options

Findings and Policy Options

Findings	Policy options
• There is limited federal guidance regarding automation in PA, and state guidance is inconsistent • Limited federal guidance on automation may be slowing the adoption of automation tools in Medicaid PA • Automated PA processes present potential risks to Medicaid beneficiaries, providers, and payers	• Issue guidance clarifying clinical expertise must be involved in reviewing and approving all adverse authorization decisions • Amend regulations to indicate that adverse decisions in FFS UM programs must be made by a human with appropriate clinical expertise

Findings and Policy Options, cont'd.

Findings	Policy options
• There is limited transparency into how automated PA systems work and their impact on costs and access to care • There is limited federal guidance regarding automation in PA	• Issue guidance to states recommending oversight of Medicaid managed care plans' use of automation tools • States should use their managed care contracts with Medicaid managed care plans to require disclosure about the use of automation in the authorization process

Clarifying Clinician Oversight Over Adverse Decisions

Policy Option 1

Issue guidance clarifying that clinical expertise must be involved in reviewing and approving all adverse authorization decisions.

- Current managed care regulations state that all adverse decisions must be "made by an individual who has appropriate expertise;" the application to decisions made by automated PA systems is unclear
- Guidance should clarify that adverse decisions must be made by a human, must be consistent with enrollees' clinical needs, and that automated systems alone cannot authorize denials or partial denials
- Guidance could also clarify how existing requirements for timeliness, notice, and appeals apply broadly, including within automated PA systems

Policy Option 2

Amend regulations to indicate that adverse decisions in FFS UM programs must be made by a human with appropriate clinical expertise.

- There is currently no requirement in FFS that an "individual with expertise" make adverse PA decisions
- Amend 42 CFR 440 to include the same PA requirements that apply to managed care under 42 CFR 438.210(b)(3)
- Introduces same requirements as policy option 1: individual clinician must issue all adverse decisions, adverse decisions must be made consistent with enrollees' clinical needs, automated systems alone cannot authorize denials or partial denials

Rationale

- Both policy options ensure clinical oversight of PA processes, reducing the risk that automated systems will independently issue incorrect adverse decisions
- There is consensus among stakeholders that requiring a human in the loop is a common and appropriate safeguard
- Both policy options creates consistency across states, and together create consistency across FFS and managed care
- Guidance clarifying notice requirements can assure stakeholders that existing beneficiary protections remain unchanged under automation

Leverage Existing Authority to Increase Disclosure and Transparency

Policy Option 3

Issue guidance to states recommending oversight of Medicaid managed care plans' use of automation tools.

- State oversight can increase visibility beyond baseline use and into its impacts, providing critical information for future policy making
- Guidance could include information about external quality review (EQR) processes; required plan-level appeals and denials reporting necessary for the Managed Care Program Annual Report (MCPAR) submitted by the state; ongoing program monitoring or contractually required reporting; and readiness reviews for new contracts
- Guidance also could recommend states mandate new reporting or other activities under Medicaid managed care contracts

Policy Option 4

States should use their managed care contracts with Medicaid managed care plans to require disclosure about the use of automation in the authorization process.

- States, as the holders of managed care contracts, are in a unique position to require transparency according to their policy and programmatic goals and needs
- States could use managed care contract provisions to implement the guidance reference in option 3, but also impose their own mandates for disclosure or reporting to permit state oversight

Rationale

- Policy option 3 provides states with guidance they can use to increase visibility into managed care plans' use of automation
  - CMS is best positioned to guide states on the ways in which federal policies and processes can be applied
  - In interviews, states endorsed CMS guidance on oversight
- Policy option 4 increases transparency into managed care plans' use of automation
  - In interviews, states reported little newly imposed oversight specific to automation in managed care
  - States can use existing authority to conduct oversight of automation

Next Steps

Next Steps

- Staff expect to include a chapter on PA automation in the June 2026 report to Congress
- We ask Commissioners to share any questions in response to these findings, principles and options:
  - Are there outstanding questions about the policy options that staff can answer?
  - Does the presented evidence support the principles and policy options?
  - Are there other factors for staff to consider while developing recommendation language and the rationale?

Policy Principles

- Automation in Medicaid PA offers administrative efficiencies for payers and providers, which can improve timeliness of approvals, beneficiary experience, and access to care.
- Transparency and disclosure are important tools in documenting and assessing the use of automation, including the nature of emerging risks.
- Due to the evolving nature of automation technologies and their increasing application, ongoing reevaluation of the oversight policy framework in Medicaid PA is warranted.

Policy Options

- Issue guidance clarifying clinical expertise must be involved in reviewing and approving all adverse authorization decisions
- Amend regulations to indicate that adverse decisions in FFS UM programs must be made by a human with appropriate clinical expertise
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