

April 9, 2026

Automation in Medicaid Prior Authorization

Draft Recommendations

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Medicaid and CHIP Payment and Access Commission

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Overview

- Project background
- Summary of findings, challenges and policy principles
- Draft recommendations
- Next steps



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



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 stakeholders believe federal guidance will provide clarity and potentially facilitate adoption; others expressed concern that standardized guidance could limit or require reworks of innovative approaches

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, cont'd.



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



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

Recommendations

Findings and Policy Recommendations

Findings

- Automated PA processes present potential risks to Medicaid beneficiaries, providers, and payers
- There is limited federal guidance regarding automation in PA, and state guidance varies
- Limited federal guidance on automation may be slowing the adoption of automation tools in Medicaid PA

Recommendations

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

Findings and Recommendations, cont'd.

Findings

- 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

Recommendations

- Issue guidance to states recommending oversight of Medicaid managed care plans' use of automation tools
- States should use their contracts with Medicaid managed care plans to require disclosure about the use of automation in the authorization process

Recommendation 1

The Centers for Medicare & Medicaid Services should issue guidance to state Medicaid agencies and Medicaid managed care plans clarifying that the language at 42 CFR 438.210(b)(3) requires an individual with appropriate expertise to review and authorize all decisions to deny service authorizations, including those proposed by automated systems.

This guidance should clarify further that (1) adverse determinations may not be made by automation tools alone; (2) adverse determinations must be made based on determinations of individual medical necessity; and (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

Recommendation 1: Rationale

- The recommendation would clarify federal requirements for oversight of PA processes, reducing the risk that automated systems will independently issue incorrect adverse decisions
 - Guidance clarifying notice requirements can assure stakeholders that existing beneficiary protections remain unchanged under automation
- There is consensus among stakeholders that requiring a human in the loop is a common and appropriate safeguard
- This recommendation can create consistency across states and managed care plans

Recommendation 1: Implications

- **Federal:** MACPAC is awaiting CBO estimates
- **States:** Benefit from additional transparency and disclosure, but may face minimal additional administrative costs
- **Enrollees:** May benefit from clearer oversight of PA decisions
- **Plans:** May have marginal impact to PA operations, but expect this to be minimal due to existing requirement
- **Providers:** Minimal direct effect, but may experience downstream impacts due to any resulting changes in PA process

Recommendation 2

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend the regulations at 42 CFR 440.230 to provide that, in fee-for-service Medicaid programs, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

Recommendation 2: Rationale

- This recommendation would ensure oversight of PA processes in Medicaid FFS, 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
- This recommendation creates additional consistency across FFS and managed care

Recommendation 2: Implications

- **Federal:** MACPAC is awaiting CBO estimates
- **States:** May face minimal additional administrative costs
- **Enrollees:** May benefit from clearer oversight of PA decisions
- **Plans:** No impact
- **Providers:** Minimal direct effect, but may experience downstream impacts due to any resulting changes in PA process

Recommendation 3

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans specifying ways in which existing regulatory oversight processes, including the external quality review process and mandated plan reporting required for Managed Care Program Annual Reports, can be used to create effective oversight of managed care plans' use of automation in utilization management (42 CFR 438.66, 42 CFR 438.350 and 42 CFR 438.66(e)(1)).

Recommendation 3: Rationale

- In interviews, states described limited visibility into plans' use of automation and endorsed CMS guidance on oversight
- CMS guidance would help states use existing mechanisms to increase visibility into plans' use of automation
 - Routine managed care oversight, including monitoring, readiness reviews and reporting
 - External quality review
 - Reporting required for Managed Care Program Annual Reports
- Complements and builds upon existing MACPAC recommendations on managed care oversight

Recommendation 3: Implications

- **Federal:** MACPAC is awaiting CBO estimates
- **States:** Benefit from additional federal guidance and technical direction, and can maintain flexibility about the manner in which oversight mechanisms are implemented
- **Enrollees:** No direct impact; over time, may benefit from clearer oversight of PA decisions
- **Plans:** Where new processes are implemented, may create new reporting or oversight requirements, increasing administrative costs
- **Providers:** Minimal direct effect, but may experience downstream impacts due to any resulting changes in PA process

Recommendation 4

State Medicaid agencies should amend their Medicaid managed care plan contracts, on a timeline that is practicable, to require disclosure or other reporting of the use of automation in plans' coverage and authorization processes described at 42 CFR 438.210. Disclosure should facilitate state visibility into the applications of automation tools and other meaningful elements of automation, such as plans' protocols for testing, evaluation, and oversight. To the extent possible, states should modify existing reporting requirements or existing oversight processes to minimize additional administrative burden.

Recommendation 4: Rationale

- In interviews, states reported little newly imposed oversight specific to automation in managed care
- States hold unique authority to impose contract standards for plan performance and reporting
- This recommendation increases transparency into managed care plans' use of automation
- Through this recommendation, states can use existing authority to conduct oversight of automation

Recommendation 4: Implications

- **Federal:** MACPAC is awaiting CBO estimates
- **States:** Benefit from additional transparency and disclosure, but may face minimal additional administrative costs
- **Enrollees:** No direct impact; over time, may benefit from clearer oversight of PA decisions
- **Plans:** May be required to increase disclosure in states where implemented; may have an overall impact on adoption of implementation among plans
- **Providers:** Minimal direct effect, but may experience downstream impacts due to any resulting changes in PA process

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Next Steps

Next Steps

- Staff will include a chapter on PA automation in the June 2026 report to Congress
- We ask Commissioners to share any questions in response to the draft recommendation language or rationale:
 - Are there outstanding questions about the recommendations that staff can answer?
 - Are there other factors for staff to consider while developing the chapter text?

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