May 7, 2026

Automation in Medicaid Prior Authorization

Recommendations

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MACPAC

Medicaid and CHIP Payment and Access Commission

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Overview

- Background and findings
- Recommendations
- Next steps

Background and Findings

Project Overview

- **Automation:** the use of technological tools such as algorithms and artificial intelligence (AI) that supplement or replace human action or decision making
- **Project objective:** understand how automation is being used in the Medicaid prior authorization (PA) process in managed care and fee-for-service (FFS) delivery systems
- We examined the PA process specifically, although there are broader applications for automation in the Medicaid program
- MACPAC and contractor conducted literature review, federal policy reviews, and stakeholder interviews

Findings

- 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
- States and managed care plans use AI and algorithms in Medicaid PA
- States and the federal government have limited visibility into plans' use of automation in Medicaid PA
- Automated PA processes present potential risks to beneficiaries, states, providers, and health plans
- Limited federal guidance on automation in Medicaid PA is slowing the adoption of automation tools

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 payers use automation
- The complexity of AI can make PA decisions difficult to assess
- Automation may introduce unseen bias or programming errors

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

- Current Medicaid regulations do not directly guide the use of automation in PA
- Stakeholders are reluctant to implement automation in the absence of federal guidance
- Varying state approaches create a fragmented regulatory environment

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

Recommendation 1 (as approved)

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 clarifying that, for determinations of medical necessity, 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 or to authorize a service in an amount, duration or scope that is less than requested, 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 individualized determinations of 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 would create consistency across states and managed care plans

Recommendation 1: Implications

- **Federal:** The Congressional Budget Office (CBO) estimates no impact to direct spending
- **States:** May benefit from clearer federal policy; may modify existing operations
- **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 (as approved)

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, for determinations of medical necessity 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:** CBO estimates no impact to direct spending
- **States:** May benefit from clearer federal policy; may modify existing operations
- **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 Centers for Medicare & Medicaid Service's (CMS's) 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
  - Managed Care Program Annual Reports
- Complements and builds upon existing MACPAC recommendations on managed care oversight

Recommendation 3: Implications

- **Federal:** CBO estimates no impact to direct spending
- **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
- **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:** CBO estimates no impact to direct spending
- **States:** Benefit from additional transparency and disclosure; may modify existing operations
- **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

Next Steps

Next Steps

- These recommendations will be subject to a vote this afternoon
- We ask Commissioners to share any feedback on content or tone in response to the draft chapter

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