Chapter 2:

Automation in Medicaid Prior Authorization

Automation in Medicaid Prior Authorization

Recommendations

2.1 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; (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

2.2 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, 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.

2.3 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 (42 CFR 438.66), including the external quality review process (42 CFR 438.350) and mandated plan reporting required for Managed Care Program Annual Reports (42 CFR 438.66(e)(1)), can be used to create effective oversight of managed care plans' use of automation in prior authorization.

2.4 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.

Automation in Medicaid Prior Authorization

Key Points

- Prior authorization (PA) is the process by which health care payers require medical providers to request and receive approval before providing certain items, services, or medications. Medicaid fee-for-service programs and managed care plans use PA to promote appropriate, cost-effective care and reduce wasteful spending.
- States, managed care plans, and providers are using automation tools, such as artificial intelligence and rules-based algorithms, to streamline steps in the PA process. When used in Medicaid PA, automation can reduce administrative burdens, facilitate faster PA decisions, and support more appropriate and cost-effective care. However, stakeholders have raised concerns about risks, such as bias, incorrect denials, and reduced transparency.
- Some states and plans are using automation tools to approve PA requests without human review. Interviewed states and plans emphasized that their automation tools do not deny PA requests and that all denials must be reviewed by a human.
- Although federal regulations cover many aspects of Medicaid PA, none explicitly addresses the use of automation in Medicaid PA. Some states and managed care plans stated that they are reluctant to implement automation due to a lack of federal guidance. Some states have passed laws concerning the use of automation in PA, but variation in these laws can create confusion or compliance burdens for managed care plans and information technology vendors.
- The federal government and states have limited visibility into when and how managed care plans use automation in Medicaid PA and the impact of automation on costs and access to care. Existing federal and state oversight and monitoring mechanisms could be adapted to improve visibility into managed care plans' use of automation.
- MACPAC proposes three principles to guide the adoption, monitoring, and regulation of automation in Medicaid:
  - 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.

CHAPTER 2: Automation in Medicaid Prior Authorization

Rising health care spending has led payers, including Medicaid, to adopt strategies that seek to contain costs while preserving beneficiary access to appropriate care. In the U.S. health care system, estimates of wasteful spending range from $600 billion to more than $1.9 trillion per year (Speer et al. 2020). Public and private insurers employ utilization management (UM) strategies to minimize unnecessary spending. Prior authorization (PA) is a primary UM strategy.

PA is the multistep process by which health care payers require medical providers to request and receive approval before providing certain items, services, or medications (Pestaina and Pollitz 2022). Some studies have shown that PA can reduce health care costs without negatively impacting care quality; however, others have raised concerns that PA can harm patients (Asher et al. 2020, 2019). A recent U.S. Department of Health and Human Services Office of the Inspector General report found that Medicare Advantage (MA) plans incorrectly denied PA requests, which may have prevented or delayed MA beneficiaries from receiving medically necessary care (OIG 2022). Furthermore, surveys of health care providers show that PA occupies a substantial portion of staff time and that some providers employ full-time staff dedicated exclusively to PA (AMA 2024, Sahni et al. 2024).

Providers and health plans have begun to use automation tools in parts of the PA process, including submitting requests and making PA determinations (Mello 2026, Tripathi et al. 2024, UnitedHealth Group 2024). Automated systems that use algorithms or artificial intelligence (AI) to conduct portions of the PA process have the potential to reduce burdens associated with PA and promote appropriate, cost-effective care (UnitedHealth Group 2024, Diane et al. 2023, Dada et al. 2022). However, providers, beneficiary advocates, and other stakeholders argue that automation may lead to harms, such as increased adverse determination rates, bias leading to incorrect adverse determinations, and reduced transparency into PA determinations (Mello et al. 2026, Lubell 2025, Permanent Subcommittee on Investigations 2024, Center for Medicare Advocacy 2022).

The Commission conducted a study to understand the extent to which states, managed care plans, and providers are using automation in the Medicaid PA process and to identify potential policy levers to oversee its use. MACPAC conducted a review of state and federal policies concerning automation; a literature review on the use of automation in PA; and interviews with stakeholders representing states, managed care plans, information technology (IT) vendors, providers, and beneficiaries. In this research, our definition of automation tools included both AI and rules-based algorithms, and we focused on the PA determination process; we did not examine the use of automation to define clinical PA criteria or the use of automation in the PA appeal process or in other elements of payers' UM systems. Where our findings examine the use of automation in the authorization decision itself, our work focused on clinical determinations of medical necessity for covered benefits.[1]

Through this work, MACPAC found that states and managed care plans deploy AI and algorithms to conduct a wide variety of functions in the Medicaid PA process. This research also identified challenges related to automation in Medicaid PA: there is limited transparency into how automation is being used and its impacts on beneficiaries and the program, and there is limited federal guidance on how states and managed care plans may use automation in the Medicaid PA process.

To address these challenges, the Commission makes four recommendations to clarify oversight of PA determinations made by automated PA systems and to promote transparency into automation's use and impacts in Medicaid PA:

2.1 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; (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

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2.4 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.

This chapter begins with a background on PA in Medicaid, automation in PA, and state and federal policy concerning automation in PA. It then describes how states, managed care plans, and IT vendors are using and governing automation in the Medicaid PA process. Next, the chapter describes challenges presented by the use of automation in the Medicaid PA process. It also presents the Commission's recommendations and associated rationale as well as implications for federal spending, states, enrollees, plans, and providers. The chapter concludes with a summary of findings and considerations.

Background

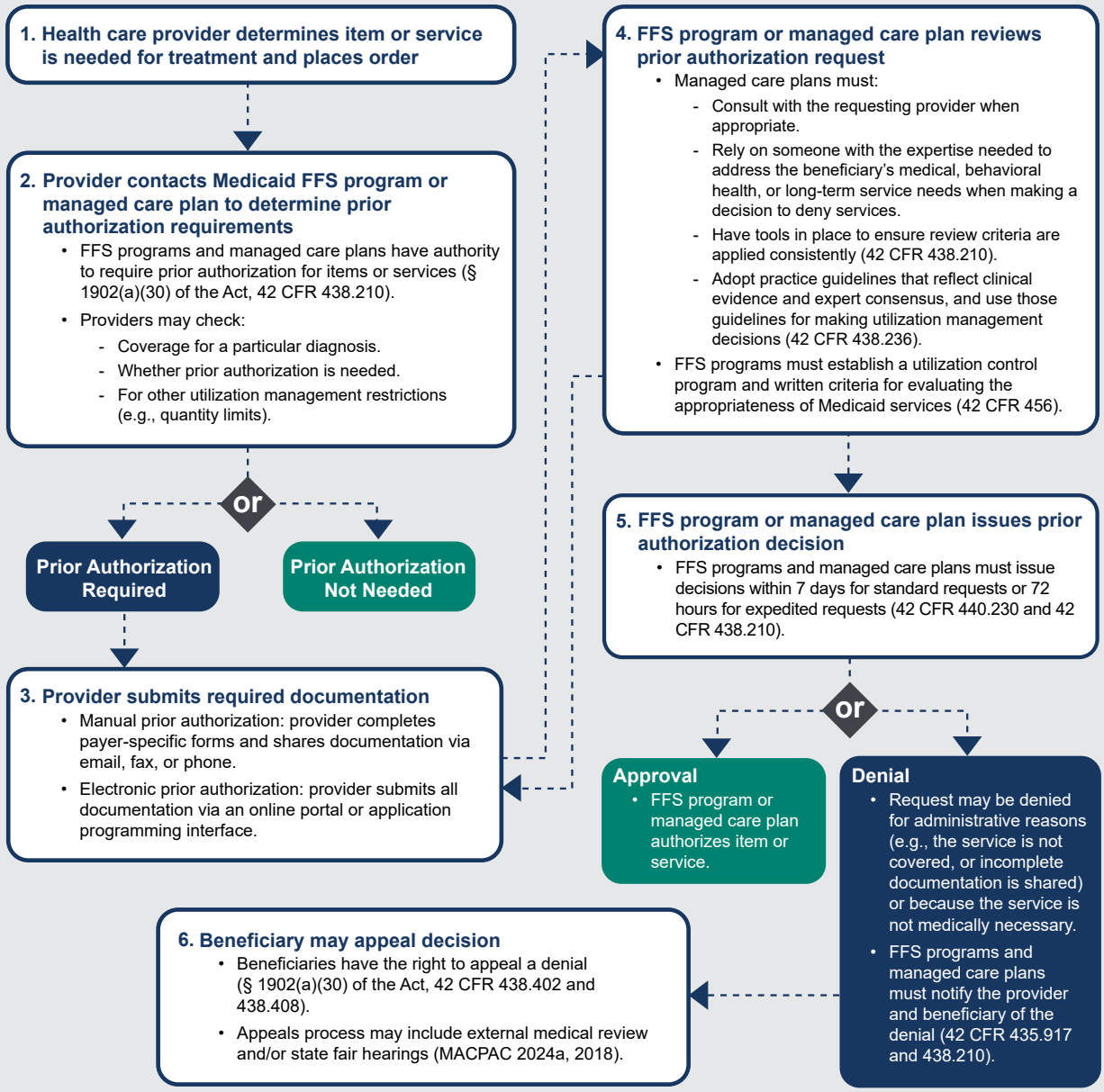
Medicaid PA

Medicaid statute and regulations provide states the authority to implement UM to safeguard against unnecessary utilization and ensure the efficiency, quality, and economy of care (§ 1902(a)(30) of the Social Security Act (the Act), 42 CFR 440.230). Likewise, federal regulations require state managed care contracts to permit managed care plans to use UM processes such as PA. State Medicaid agencies and managed care plans have flexibility to determine what services and medications require PA, with some limitations (§ 1902(a)(30) of the Act, 42 CFR 438.210). For example, Medicaid payers cannot impose PA requirements for any screening services provided under the early and periodic screening, diagnostic, and treatment benefit (CMS 2014).

In a typical PA process (Figure 2-1), health care providers submit clinical and administrative information to a payer, which reviews and issues a PA decision (Pestaina and Pollitz 2022). In straightforward cases, the provider submits documentation to demonstrate the necessity of the care, the payer reviews and approves the PA request, and the service or item is provided to the patient. In cases in which the request is not approved, the payer may request additional documentation, partially deny the request (e.g., approving less than what was requested), or deny

the request outright. Payers may deny PA requests because the plan does not cover the requested services, the provider is out of network, or the request is incomplete (often referred to as administrative denials) or because the request does not meet the plan's medical necessity criteria. Partial or full denials are commonly called adverse decisions or adverse determinations.[2]

FIGURE 2-1. Medicaid Prior Authorization Process for Medical Services and Items



Notes: FFS is fee for service. The Act is the Social Security Act. This process diagram does not apply to prescription drugs.

Source: Adapted in 2026 from MACPAC 2024.

The services and medications that require PA can vary among state Medicaid programs and plans. Medicaid services that commonly require PA include non-emergency medical transportation, durable medical equipment (DME), behavioral health services, inpatient hospital stays, inpatient and outpatient surgeries and procedures, rehabilitation services, long-term services and supports (LTSS), and prescription drugs (KFF 2018).

Regulation of Medicaid PA

Federal regulations guide how Medicaid fee-for-service (FFS) programs and managed care plans can implement PA. For example, payers must make PA decisions within a certain time frame and expedite requests if beneficiaries need urgent medical care. Federal regulations also prohibit payers from arbitrarily denying a service based on a beneficiary's diagnosis or illness type (42 CFR 440.230, 438.210). States can impose additional PA restrictions on managed care plans, such as imposing shorter decision time frames and prohibiting PA for certain items, services, or medications (42 CFR 438.210).

In 2024, the Centers for Medicare & Medicaid Services (CMS) issued its Advancing Interoperability and Improving Prior Authorization Processes final rule (CMS-0057, the interoperability rule), which introduced new requirements impacting key aspects of PA (CMS 2024a). The new requirements include: (1) shorter time frames for PA decisions in Medicaid managed care (7 days instead of 14), (2) that payers inform providers of the specific reasons for adverse decisions, (3) public reporting of PA metrics, and (4) implementation of new PA application programming interfaces. The new application programming interfaces (APIs)[3] will help with information sharing among payers, providers, and patients to reduce administrative burden and promote continuity of care and transparency. The rule introduces decision time frames and reporting requirements to Medicaid FFS, which have not been subject to such requirements in the past. These provisions take effect in 2026 and 2027 and apply to State Children's Health Insurance Program (CHIP) payers (FFS and managed care), MA plans, and Qualified Health Plans (CMS 2024a). This rule does not apply to prescription drugs; however, the 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule would extend many of these requirements to PA for prescription drugs (CMS 2026, 2024a).

Oversight of Medicaid PA

Medicaid UM, including PA, is subject to federal and state oversight. Though states have the flexibility in how they implement PA, CMS can exercise its oversight authority to audit, correct, or disapprove state practices not in compliance with federal statute or regulations (42 CFR 430). Federal regulations impose requirements on state managed care contracts, including PA policies and procedures, decision time frames, and notices (42 CFR 438.210). CMS reviews and approves state managed care contracts and, through its review, can assess contractual compliance with the standards set forth in regulation (42 CFR 438.3).

State Medicaid agencies oversee their managed care plans' compliance with contractual requirements, including those related to PA (42 CFR 438.66). States must contract with external quality review organizations (EQROs) to conduct regular reviews of their managed care plans' performance, including plans' compliance with UM and PA requirements (42 CFR 438.350–438.370). Although the EQRO review guidance does not require collection of specific data elements related to UM and does not require that EQROs assess whether PA denials are clinically appropriate, CMS includes optional guidance for interviewing UM staff and assessing policies and procedures (CMS 2023).

Additionally, Section 1932(b)(4) of the Act requires managed care plans to have an internal system for beneficiaries to challenge denials of care resulting from PA. Federal regulations specify the processes and timelines related to denials and appeals and allow states to modify certain aspects of the process (e.g., shorter time frames and external medical review) (42 CFR 438.210).

Automation

MACPAC defines automation as the use of technological tools such as algorithms and AI that supplement or replace human action or decision making. This definition of automation does not include IT tools that automate or validate information transmission, such as APIs. There are important distinctions between different types of automation technologies, such as algorithms and AI, that are relevant to PA practices in Medicaid. The following definitions apply throughout this chapter (Box 2-1).

Automation in PA

Payers and providers can use automation in nearly all steps of the PA process. For example, providers can use automation tools to prefill forms, check compliance with policies, predict decisions at the point of care, and retrieve documents for PA appeals (Mello 2026). Payers can use automation to convert improperly formatted PA requests into an interoperable format, reducing decision time frames (Tripathi et al. 2024). Payers also can use automation to make PA decisions (UnitedHealth Group 2024). According to publicly available information, most health plans do not allow automated PA systems to issue adverse decisions and instead allow them to approve PA requests or refer requests to a human reviewer who issues adverse decisions when appropriate (Miller et al. 2024). Such configurations are often referred to as "human-in-the-loop" policies.

These applications present many potential benefits, including reduced administrative burdens, faster decision time frames, and more appropriate and cost-effective care for beneficiaries. For example, one case study found that generative AI reduced the time required to draft a PA request letter for orthopedic surgery from 1 to 2 hours to 10 minutes (Diane et al. 2023). IT vendors have reported up to a tenfold increase in the speed of PA submissions after switching to automated processes, with a median approval time of 29 seconds in some cases (UnitedHealth Group 2024). Finally, some research has found that automation tools can make PA decisions that result in more appropriate, cost-effective care. For example, one study applied a rules-based algorithm to identify cases in which patients could be shifted to lower-cost services without reducing quality of care (Dada et al. 2022).

BOX 2-1. Definitions

Algorithm: A procedure or set of rules that is applied to a dataset to achieve a certain function or purpose. In the context of artificial intelligence (AI), an algorithm is the logic by which an AI model operates (IBM 2024). In the context of prior authorization, CMS defines algorithms as a decisional flow chart of a series of if-then statements that leads to a given output (e.g., if the patient has a certain diagnosis, they should be able to receive a test) (CMS 2024).

Artificial intelligence (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. AI systems use machine- and human-based inputs to perceive real and virtual environments; abstract such perceptions into models through analysis in an automated manner; and use model interface to formulate options for information or action (CMS 2024).

Generative AI: AI models that draw from large swaths of existing data to create complex original content such as long-form text, high-quality images, or realistic videos or audio (IBM 2024b). The data that generative AI models draw from may include large-language models which use technology to learn from unstructured, free-text data to improve the validity and quality of generated data (Toner 2023).

Predictive AI: AI models that draw from targeted historical data to find patterns and forecast future outcomes about the most likely upcoming event, result, or trend (IBM 2024c).

However, automated PA systems present potential risks, such as increased denial rates, bias, and reduced transparency. For example, the U.S. Senate Permanent Subcommittee on Investigations found that implementation of automation initiatives in at least one MA plan's PA process coincided with increased rates of denials for post-acute care (10.9 percent in 2020 to 22.7 percent in 2022) (Permanent Subcommittee on Investigations 2024). AI-based automation tools may be biased if they are trained on data that are not representative of the population they encounter in production and may make incorrect decisions if social determinants of health are not represented in patient data (Mello et al. 2026). Automation may also reduce transparency into the PA decision making process because of the complexity of advanced AI-based tools and because IT vendors and health plans may hold exclusive rights to automation tools (Center for Medicare Advocacy 2022). Finally, risks may persist under human-in-the-loop policies if human reviewers do not conduct thorough reviews or if requests are presented in a manner that biases reviewers toward agreeing with automated decisions (Mello et al. 2026).

Regulation, guidance, and oversight of automation

Existing Medicaid statutes and regulation do not explicitly contemplate or address the use of automation tools in Medicaid PA. Medicaid managed care regulations require that PA decisions be made by an individual with the "appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs" (42 CFR 438.210(b)(3)). Though the use of the word "individual" implies that a human must be involved, this regulation does not explicitly bar automation tools from issuing adverse decisions. In response to public comment on the interoperability rule, CMS acknowledged the possibility of automation in authorization decisions but has not changed regulatory language to date (CMS 2024a). There is no equivalent regulatory provision requiring that an individual with expertise review PA decisions made in Medicaid FFS. Additionally, there is no federal requirement obligating states to collect information from managed care plans about if and how they use automation in Medicaid PA.

Outside of the Medicaid program, CMS has issued guidance regarding PA automation in MA plans. A "Frequently Asked Questions" guidance document issued following the 2024 Medicare Parts C and D final rule provided guidance regarding how and when algorithms or software tools may be used in PA (CMS 2024b). The guidance states that although MA plans can use AI or algorithms to assist with PA decisions, automation must not replace patient-specific evaluations to ensure equitable and accurate application of coverage criteria. It states that automation tools cannot deny coverage based solely on predictions and that decisions must be based on the "individual patient's medical history, the physician's recommendations, or clinical notes." The guidance also states that AI cannot be used to shift the coverage criteria over time or apply other internal coverage criteria that are not otherwise publicly available. CMS recommends that MA organizations should ensure the tools do not perpetuate or exacerbate existing biases or introduce new biases in accordance with non-discrimination requirements in Section 1557 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (CMS 2024b).

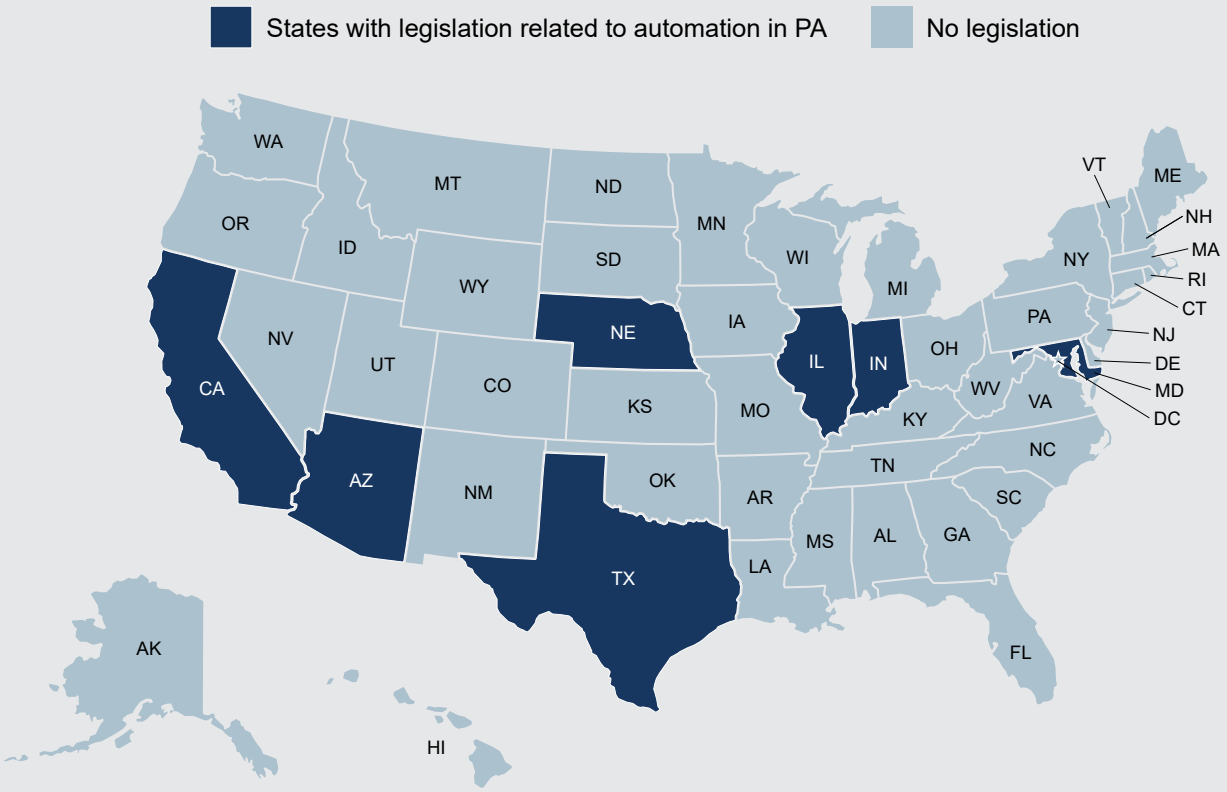
The legislative and executive branches have not acted to legislate or regulate automation in PA. Congress has shown interest in automation generally and in health care specifically but has not taken legislative action to date (Bipartisan House Task Force on Artificial Intelligence 2024, Chu et al. 2024, Committee on Finance 2023). The Trump Administration's AI strategy has focused on reducing regulatory burdens for AI development and applications and has identified state AI regulations as a barrier to innovation. The Administration issued an executive order directing the Secretary of Commerce and Attorney General to identify and take action against onerous state AI regulations, and the Administration has called on Congress to preempt state AI laws (White House 2026, Executive Office of the President 2025).

As of December 2025, seven states had passed laws to regulate the use of automation in PA under their authority to regulate commercial health plans (Figure 2-2 and Table 2B-1). These laws do not define automation uniformly: some states (California, Illinois, Texas) include both AI and rules-based algorithms in their definitions, while other states (Arizona, Maryland,

Nebraska) include only AI-based tools. Six of the seven states (Arizona, California, Illinois, Maryland, Nebraska, and Texas) passed laws requiring that a human review all adverse decisions issued by health plans. Some state laws include additional measures to protect beneficiaries. For example, California and Maryland require automation tools to base decisions on patients' individual clinical information, bar payers from making PA decisions based solely on group data, and prohibit payers from using automation to discriminate against protected classes. State laws also take a varying approach to transparency. California, Maryland, Nebraska, and Texas require UM entities to make automation tools available for audit by request. Only two state laws have public disclosure requirements: Nebraska requires utilization review entities to publicly disclose if they use AI for PA decisions, and Indiana requires plans to publish their PA requirements and approval and denial statistics.

The National Association of Insurance Commissioners developed a model bulletin addressing the use of AI in insurance, which has been adopted by 25 states, and is currently piloting an AI evaluation tool for use by state regulators to identify uses and vulnerabilities in AI use by insurers, including PA (NAIC n.d., NAIC 2023).

FIGURE 2-2. States with Legislation Related to Automation in Prior Authorization



Note: PA is prior authorization.

Source: MACPAC and Mathematica, 2025 federal and state policy review.

Current Use and Oversight of Automation in Medicaid PA

In our interviews, all states and managed care respondents reported using automation tools, most often rules-based algorithms that use clinical criteria to determine medical necessity. Stakeholders stated that some forms of automation have been in use much longer, particularly programmed algorithms or programs that categorize and route inbound electronic PA requests for approval or review. Interviewees reported using automation more frequently for certain services, such as imaging services, DME, dental services, and pharmaceuticals.

The PA process can be lengthy and complex. Figure 2-3 shows the typical steps required for PA in Medicaid programs (as shown in Figure 2-1) and the types of automation that may be employed to address them. Appendix 2A includes a complete table (Table 2A-1) of uses of automation throughout the Medicaid PA process, including challenges cited by the literature and our interviewees.

FIGURE 2-3. Medicaid Prior Authorization Process and Potential Automation Use Cases

Notes: PA is prior authorization. AI is artificial intelligence. FFS is fee for service. NLP is natural language processing.

Source: Mathematica and MACPAC, 2025 literature review and interviews.

States and providers reported using automation to synthesize and analyze large amounts of information and to extract information from sources such as policy manuals, electronic health records, clinical notes, and PA requests. One state reported using an AI tool that allows caseworkers to query a long-term care coverage manual via chatbot, simplifying the process for assessing coverage and authorization policies. States reported using generative AI systems to promote administrative efficiency in the PA review process. Examples include tools that convert unstructured data from submitted requests into structured data for review, summarize clinical reviewers' notes when responding to appeals, convert faxed PA submissions into searchable documents, or detect potentially fraudulent requests. Providers reported using automation for similar administrative-efficiency applications, such as transferring unstructured clinical data into authorization requests, and thus, their use may not be exclusive to Medicaid programs or populations.

A subset of stakeholders reported using automation tools to make PA decisions. These stakeholders consistently reported that their automation tools do not issue adverse decisions and only approve requests or refer them for clinician review. They stressed that their PA systems still rely exclusively on human review for adverse determinations. One state reported its system will issue automated denials for administrative reasons (e.g., when a PA is not required for a service or the request is incomplete), but noted that the system will notify the submitting provider of the reason for denial and will direct them to resubmit in these cases. Stakeholders described automation as a technology used primarily to expedite approvals and route requests to individuals with the best expertise for a given request (e.g., a pharmacist for a prescription PA). Stakeholders also stated that automation can approve simpler requests and leave reviewers more time to focus on complex PAs.

Despite the wide range of applications reported, AI use in PA remains in the early stages. For example, states and IT vendors reported a more limited use of AI-based tools in FFS programs than in managed care. Similarly, some stakeholders stated that smaller (often rural) systems face financial and workforce barriers to adopting automation. This dynamic may result in an uneven distribution of automation's potential benefits, with less-resourced systems not fully realizing its efficiencies or benefits. However, stakeholders in all groups expect the use of automation tools in PA to expand in the future as states use automation to reduce spending on program administration and oversight and exchange knowledge from their implementations.

Automation oversight structures

Some state Medicaid agencies have implemented governance structures, such as oversight boards and ethics frameworks, to monitor and guide the use of automation tools in their states' programs. Medicaid programs have long used algorithms, particularly within clinical decision making. With increasing adoption of AI, stakeholders reported an increase in interest in AI governance boards or groups, and multiple states reported implementing such structures to monitor and guide the use of AI in their Medicaid programs. These groups typically review proposed applications of AI in their states' Medicaid programs and address concerns related to beneficiary impact, human oversight, and data privacy. Other states reported they do not have formal governance structures and delegate oversight roles to existing Medicaid offices or larger governance bodies. For example, one state uses its Medicaid Transformation Management Office to vet automation projects for compliance, fiscal impacts, and potential risks.

Interviewees did not identify any formal state oversight and monitoring structures specific to automation in Medicaid PA. State Medicaid agencies reported they have access to PA data through existing compliance activities and reporting metrics (e.g., percentage of PA requests resulting in a partial or full denial). However, interviewees reported that states may detect automation only if it results in a noticeable change in these metrics. Some states mentioned plans to implement new PA timeliness reporting requirements that may enable this, but no respondents reported developing metrics specific to assessing the performance of automated PA tools. Some states reported that they lack time and resources to develop

oversight and monitoring mechanisms for automation in PA. Interviewees stated that it is difficult for some states to develop oversight policies on their own, and that states typically look to the federal government for guidance to develop oversight mechanisms.

Some managed care plans, providers, and IT vendors have established governance structures and ethics frameworks. For example, one plan published a Statement of AI Principles, which outlines the health plan's requirements for accountable and compliant use of AI, including the requirement that clinician reviewers retain decision making authority for any adverse decisions. The American Medical Association advocates for legislative and regulatory action that increases oversight of AI in PA, including measures to increase transparency and ensure clinician review of PA requests (AMA 2025). Some IT vendors have taken a similar approach, with one framework describing best practices such as model validation and monitoring to reduce bias and reviews by clinicians to ensure fair and accurate determinations. Additionally, a group of private and public sector stakeholders has created the Coalition for Health AI, which focuses on AI in health care broadly. The coalition has published best practices for health care professionals developing, implementing, or using AI and has convened an AI-supported PA systems workgroup (CHAI 2026). Additionally, the National Health Law Program, an organization that has advocated on behalf of Medicaid beneficiaries, has released a list of principles for automated decision making systems (i.e., AI and algorithms) in public benefits such as Medicaid. One principle asserts that government agencies must ensure due process for all benefits-related decisions (Machledt and Edwards 2023).

Private and public sector governance structures are subject to limitations. Effective governance requires automation subject matter expertise and resources, which some states and health systems may lack. Stakeholders stated that smaller health systems may not have the resources and expertise to implement effective oversight structures, potentially exposing their patients to greater risk. Additionally, state governance bodies that are not legislatively mandated may have limited resources, may rely on oversight mechanisms that predate the adoption of automation in the PA process, and may not be suited for automation governance. Private sector governance structures are voluntary and self-regulated: health plans and vendors can choose whether to establish or participate in governance structures and can write their own rules, which may limit their effectiveness. Finally, information on governance structures was not broadly available as part of our policy scan and literature review; as such, it is difficult to know the breadth or effectiveness of such approaches.

Challenges with Automation in PA

The findings from our literature review, policy scan, and interviews revealed challenges posed by automation in Medicaid PA, including limited transparency and inconsistent federal guidance.

Limited transparency

Stakeholders representing beneficiaries and providers raised concerns about transparency in interviews. They stated that they have little visibility into how and when automation is being used, how automation tools make PA decisions, and the approval and denial rates for automated systems. Absent this information, it is difficult to determine whether automated systems are making fair PA decisions or impacting beneficiaries' access to care. Beneficiary advocates stated that payers and UM entities often cited intellectual property protections to prevent advocates from examining automation tools. Advocates raised similar concerns in literature, noting that IT developers hold exclusive rights over the automation tools they develop, which can limit transparency into how these tools function (Center for Medicare Advocacy 2022).

The nature of AI itself also presents barriers to transparency. Modern AI systems are complex, employing hundreds or even thousands of layers of analysis to produce outputs. Stakeholders stated that the complicated nature of AI limits understanding of how and why PA decisions are made. One beneficiary

advocate warned that there is little information on whether AI tools are correctly applying care criteria beyond the outcomes themselves. Separately, a state representative noted that AI is not auditable in the same way as traditional PA because of its black box nature.

States can use their existing contracting and oversight authority to identify when and how managed care plans use automation in PA, but our evidence suggests such practices are not widespread. There is no federal requirement obligating states to collect information from managed care plans about if and how they use automation in Medicaid PA. States may leverage their existing contracts and oversight activities for managed care plans to identify adoption of automation, but it is unclear from our research how many choose to do so. Interviewees acknowledged that automation may be disclosed only voluntarily or on an ad hoc basis, or it may be detectable by the state when it results in a considerable or noticeable change in PA outcomes as they are tracked over time. CMS and states have existing oversight mechanisms, such as external quality review (EQR), Managed Care Program Annual Reports (MCPARs), and state contracting authority, that may provide insight into automation use. However, MCPAR does not require states to collect data on the use of automation in PA determinations. No respondents in our interviews reported using these mechanisms to conduct routine oversight of health plans' use of automation. Federal stakeholders stated that CMS could collect more data on automation in Medicaid PA by adding new reporting requirements to MCPAR, potentially aligned with implementation of the interoperability rule.

Limited transparency into automation systems also prevents states and the federal government from monitoring technical issues that impact PA decisions, such as data bias or programming flaws. An AI-based system can produce biased outputs if it is trained on data that are not representative of the population it will encounter in production. This is known as sample bias and is an inherent risk in AI (Jones 2019). Research has shown that sample bias can lead to skewed outputs in clinical AI tools. For example, AI models are more likely to misdiagnose illnesses among Medicaid beneficiaries and individuals of racial minority groups when they are not trained on data that represent these populations (Chen et al. 2023).

In interviews, stakeholders warned that this type of bias may produce incorrect adverse determinations for Medicaid beneficiaries. A provider representative stressed the importance of AI tools being trained on appropriate data and warned that commercial data do not reflect the complex patient population and services covered by Medicaid. Separately, a state representative noted that Medicaid beneficiaries may have less of a "digital footprint," such as electronic health records, than the general population, which may limit the availability of appropriate data.

Other programming errors can produce inaccurate PA decisions in complex AI-based systems and simpler algorithms. For example, one beneficiary advocate reported they discovered that a state's PA algorithm had a critical coding error that led to denials of care for large numbers of beneficiaries.

There are no data on the impact of these risks on adverse determination rates in Medicaid, but evidence from other insurance programs shows that automation may increase adverse determination rates. No studies to date have compared rates of denials or wrongful denials with and without automation (Mello et al. 2026).

Inconsistent federal guidance

Federal and state policy govern Medicaid managed care and FFS PA operations, such as timeliness, approval processes, and state oversight of managed care plan operations. However, adoption of automation in PA has rapidly evolved in recent years, and these policies do not directly regulate, guide, or monitor its use in PA. Currently, there are no requirements in statute or regulation that specifically address the use of automation in either Medicaid managed care or FFS PA. Language in federal Medicaid managed care regulations requires clinical oversight of adverse decisions, similar to the MA program; however, this language is silent on automation specifically. FFS PA regulations lack the same requirement for expert review of all adverse PA determinations.

Stakeholders reported that the absence of federal guidance makes many states and managed care plans reluctant to implement automation tools, especially in outward-facing applications like PA. One managed care plan stated that the lack of guidance and regulation specific to AI contrasts with the extensive guidance that CMS and other regulators have issued on topics such as data security, storage, and transmission. Stakeholders reported that some plans and states are reluctant to implement automation systems that may be superseded by federal action in the future, requiring costly reworks. One IT vendor noted there are no clear requirements for AI safety or testing. Other stakeholders reported they are wary of any public relations risk in implementing automation tools in the absence of guidance on these topics. States and Medicaid managed care plans have sought guidance from CMS about existing regulatory frameworks and permissible uses of automation in PA. CMS has acknowledged there is no Medicaid-specific guidance but points to other guidance, such as Medicare guidance, as a resource.

By contrast, states have introduced varying policies governing automation in PA and other areas. These policies vary across states both in how they define automation and in how they regulate it. For example, California and Maryland bar payers and UM entities from using automation tools to discriminate against protected classes. Stakeholders described navigating varying state laws and regulations and warned that variation creates additional compliance burdens for IT vendors, health plans, and UM entities implementing automation. For example, one MCO representative described review and approval processes for new IT, including automation tools, that vary from state to state and require substantial time and resources to navigate. A provider representative shared similar concerns, warning that variation in state approaches could create a fragmented regulatory environment that is difficult for providers and payers to navigate.

Many stakeholders spoke in support of federal action on automation in Medicaid PA, though some expressed reservations. State representatives supported federal regulations, guidance, and technical assistance. For example, one proposed the federal government set a floor of regulations that the states can build on. Multiple states supported CMS issuing guidance on PA automation oversight to help improve their own oversight practices. Managed care plans, providers, and vendors also expressed a need for regularly updated, standardized rules and guidance for testing, implementation, and safety that apply across states and patient populations. Furthermore, interviewees across stakeholder groups noted the importance of distinguishing between rules-based algorithms and machine-learning AI systems and warned that inconsistent definitions may lead to overregulating basic tools (such as clinical algorithms) or underregulating higher-risk AI models. However, provider and beneficiary advocates supported a broad definition of AI that includes rules-based algorithms, arguing that a narrow definition of AI may lead policymakers to overlook risks posed by rules-based algorithms.

Some states and managed care plans expressed reservations about federal regulation of automation in PA. A representative from a state with an existing AI oversight and governance approach expressed concern that federal action may require the state to rework its current approach to automation. Another state representative warned against the federal government taking a one-size-fits-all approach to automation that does not account for variation in states' size, resources, and Medicaid policies. State representatives also raised concerns about the additional compliance burden associated with new federal regulations, with one stating that implementation of the interoperability rule has already strained budgets and staff capacity. A managed care plan representative stated that federal regulations may limit its ability to pursue innovations that can shorten approval times, arguing that they may struggle to meet PA turnaround requirements without advancements in automation.

Principles for Automation in Medicaid PA

MACPAC proposes three principles to guide the adoption, monitoring, and regulation of automation in Medicaid PA. These principles reflect findings from MACPAC's research and highlight the views of the Commission.

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

Evidence from the literature review and stakeholder interviews identified areas in which automation can introduce efficiencies to the PA process. This reduces burdens for providers, reduces PA decision time frames, and produces more appropriate and cost-effective care (UnitedHealth Group 2024, Diane et al. 2023, Dada et al. 2022). In interviews, states and managed care plans reported using automation to synthesize large volumes of information, extracting data from electronic health records, and to issue authorization approvals. Additionally, providers reported that they use automation to expedite the submission of PA requests and appeals.

However, literature and stakeholder interviews identified potential risks posed by automation: automation tools may produce incorrect adverse determinations and reduce transparency into PA processes (Mello et al. 2026, Center for Medicare Advocacy 2022). Policy targeting automation in Medicaid PA should carefully balance these potential risks and benefits to ensure that automated PA processes are used to provide Medicaid beneficiaries with timely, cost-effective, and clinically appropriate care.

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

Stakeholder interviews revealed that although managed care plans, and to a lesser extent, states, are widely implementing automation tools, much is unknown about how they are being implemented and used and their impact on costs and access to care. Transparency into automation's use and impacts can reduce these unknowns and allow states and the federal government to better monitor potential risks (such as data bias and faulty programming). Disclosure and reporting requirements may offer states and other stakeholders the necessary transparency to help mitigate such risks. Policies addressing automation in Medicaid PA should reduce barriers to data and information about automation systems and encourage the collection of useful data about automation's development, implementation, and impacts. These policies should balance the need for this information while preserving opportunity for innovation in the field.

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 health care. For example, the number of AI medical devices approved by the Food and Drug Administration increased twelvefold between 2018 and 2023 (Maslej et al. 2025). In interviews, stakeholders predicted that the use of automation in Medicaid PA will expand as well. One stakeholder claimed that AI may improve to the point that it provides faster and more accurate PA decisions than human clinicians. Given this rapid evolution in capabilities and applications, some of the risks identified by stakeholders may fade, while new risks may emerge in their place as automation use and application continues to grow. The federal policy framework addressing automation in Medicaid PA should be regularly reevaluated, using applicable available data, to minimize obstacles to technological innovation while remaining responsive to emerging risks.

Commission Recommendations

The following recommendations seek to address the challenges and findings identified by this research. The first pair of recommendations addresses the risks posed by automation tools and aims to strengthen oversight of adverse determinations of medical necessity for covered benefits. The second pair seeks to increase disclosure and transparency of managed care plans' use of automation in PA. Both

address the lack of federal guidance on automation by recommending federal action.

Clarifying oversight over adverse decisions

This project found that automation may pose risks to beneficiaries and providers through the way automated systems are used in adverse authorization determinations. Stakeholders reported that clinical and human oversight of PA processes can serve as a safeguard against this risk. However, there is limited federal guidance regarding automation in PA generally, and the existing policy framework does not clearly articulate federal minimum standards for direct oversight of PA automation. The following recommendations seek to address these challenges.

Recommendation 2.1

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; (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

Rationale

Currently, regulations require "that 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" (42 CFR 438.210(b)(3)). This text does not offer clear direction on how automation may or may not be used in PA decisions. The requirement that decisions be made by "an individual" suggests that all adverse determinations must be made by humans; it does not explicitly state that automated systems cannot make adverse determinations, nor does it state if automation tools may approve PA requests. Furthermore, stakeholders did not identify this regulation as clear federal guidance on the use of automation in PA.

CMS should issue guidance clarifying that the regulatory text requires (1) an individual with applicable expertise must authorize all denials or partial denials; (2) that denials or partial denials must be made consistent with enrollee-specific medical, behavioral, or LTSS needs, which cannot be predicted through population-based models alone; and (3) that automated tools alone cannot authorize denials or partial denials. The guidance could clarify that automation tools may be used to review, route, and approve PA requests and aid decision making by human reviewers. Guidance could also clarify how federal regulatory requirements for Medicaid managed care plans apply to the issuance of notices when automation is used (42 CFR 438.404, 438.210). These regulations require that managed care plans inform beneficiaries of the reason for adverse determinations and make available upon request information such as medical necessity criteria and processes for setting coverage limits.

This recommendation addresses the risks that automation tools make incorrect adverse determinations due to data bias or programming errors. These risks may limit or delay access to Medicaid beneficiaries, who are more likely to report challenges with PA than other populations (Pollitz et al. 2023). This recommendation would help mitigate some of these risks by clarifying that an individual with expertise must review adverse medical necessity determinations, including those made by automated PA systems. Reviewers can use their expertise to identify and correct course when automated systems make incorrect adverse determinations. In interviews, multiple states expressed that having a human reviewer is a necessary safeguard for automated PA systems, and managed care plans, IT vendors, and states reported that they already require human review of adverse determinations.

This recommendation also addresses the absence of federal guidance on automation in PA and the variation in state approaches to automation. Some states have passed laws requiring human review for adverse PA decisions, while others have not. Guidance would clarify this as a consistent requirement across states, reducing regulatory variation for managed care plans, UM entities, and IT vendors. It would also address concerns that stakeholders raised about the emergence of a patchwork of state laws and policies by providing clear and consistent federal regulatory standards. The recommendation would increase Medicaid alignment with MA regulations, which also require adverse organization determinations be made by individuals with relevant medical expertise (42 CFR 422.566(d)) and made consistent with enrollee-specific circumstances, which CMS clarified cannot be predicted through population-based models alone (42 CFR 422.101(c)(i)(C); CMS 2024b).

Implications

Federal spending. The Congressional Budget Office (CBO) estimates this recommendation would not have an effect on federal direct Medicaid spending.

States. The recommendation would clarify existing regulations under 42 CFR 438.210(b)(3). As such, this would not impose a new requirement on states. From our interviews, many states and their contracted managed care plans have policies and procedures that align with these clarifications. Some states may need to adjust their managed care contracts and oversight processes to ensure that they are adequately governing and monitoring managed care plan compliance consistent with this new guidance.

Enrollees. Ensuring expert oversight of all adverse decisions, including those made by automated systems, may protect beneficiaries from incorrect adverse determinations. Any reduction in the number of incorrect adverse determinations can improve access to care and reduce administrative burdens for beneficiaries seeking care that is subject to PA, particularly for services such as LTSS or behavioral health services that are frequently subject to PA.

Plans. Current managed care regulations require any adverse determination be made by an individual with appropriate expertise. Our stakeholder interviews also indicate that these review provisions are commonly used safeguards in automated PA systems. Therefore, we do not anticipate that plans would need to make substantial changes to their PA processes as a result of this guidance. In the event that some managed care plans must rework existing automation structures to comply with this guidance, those plans may see an increase in administrative burden to modify their policies and procedures.

Providers. PA requests and appeals can create administrative burden and costs for providers. Requiring review of adverse determinations may reduce the number of incorrect adverse decisions issued by managed care plans, which in turn would reduce the administrative burden associated with submitting and appealing those decisions.

Recommendation 2.2

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, 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.

Rationale

This recommendation would create alignment between managed care and Medicaid FFS programs. Although Medicaid FFS programs have the authority to implement PA, FFS PA regulations lack the same requirements found in managed care regulations (42 CFR 440.230). Specifically, FFS regulations do not require an individual with expertise to review all adverse decisions. Currently, FFS regulations allow the Medicaid agency to place appropriate limits on a covered service based on such criteria as medical necessity or on utilization control procedures (42 CFR 440.230(d)). There are broad requirements that the Medicaid agency must have an agreement with the state health agency or appropriate medical agency to review the appropriateness and quality of Medicaid services by professional health personnel,

but this is not specifically tied to PA decisions (42 CFR 456.6). The updated regulation should indicate that evaluations by appropriate personnel supporting adverse decisions must reflect the specific medical needs of the enrollee, consistent with the Medicaid managed care regulation. Consistent with the first recommendation, this recommendation would require that, for medical necessity determinations regarding covered benefits, an individual with appropriate expertise must make all denials or partial denials, and denials or partial denials must be made consistent with enrollee-specific medical, behavioral, or LTSS needs. CMS could offer additional clarifying context in the preamble to a proposed regulation articulating the alignment with the managed care regulation and the interpretation of this language with regard to automation. Although state interviewees indicated that the use of automation in FFS is more limited than in managed care, we found no evidence that the standards for PA oversight should differ. Instead, the same risks may arise in PA in both delivery systems.

This recommendation would help mitigate some of the risks posed by automation in PA by clarifying that an individual with expertise must review adverse decisions, including those made by automated PA systems. Such reviewers can use their expertise to identify and correct course when automated systems make incorrect adverse decisions. As noted previously, stakeholders expressed that human oversight is a necessary safeguard for automated PA systems, and managed care plans, IT vendors, and states reported that they already have such policies for adverse decisions.

This recommendation addresses the absence of federal guidance on automation in PA and the variation in state approaches to automation. Regulatory changes for FFS would create consistency for the UM entities and IT vendors that serve Medicaid FFS programs. Creating this consistency addresses the concerns that many stakeholders raised about the emergence of a patchwork of state laws and policies by providing clear and consistent federal regulatory standards.

Aligning FFS and managed care comports with recent federal regulatory action in the imposition of similar requirements across Medicaid payers—for example, the alignment of PA decision time frames required by the interoperability rule. As discussed above, this recommendation would also increase Medicaid alignment with MA regulations (42 CFR 422.566(d), 422.101(c)(i)(C); CMS 2024b).

Implications

Federal spending. CBO estimates this recommendation would not have an effect on federal direct Medicaid spending.

States. In interviews, state FFS programs that use automation in PA indicated that they require clinician review of adverse decisions. However, it is not clear that all states require this safeguard because it is not specified in current federal regulations. Given this, some states may need to implement new clinical reviews and policies in their PA systems. States may need to engage with their internal or external IT teams to modify existing systems to route non-approved PA requests to the required reviewers.

Enrollees. Ensuring oversight of all adverse decisions, including those made by automated systems, may protect beneficiaries from incorrect adverse determinations. Any reduction in the number of incorrect adverse determinations can improve access to care and reduce administrative burdens for beneficiaries seeking care that is subject to PA, particularly for services such as LTSS, behavioral health services, and prescription medications that are frequently subject to PA.

Plans. This recommendation applies to state FFS programs and would not have a direct impact on managed care plans.

Providers. PA requests and appeals create administrative costs for providers. Requiring human review and oversight may reduce the number of incorrect adverse decisions issued by state FFS programs, which in turn would reduce administrative costs associated with submitting and appealing those PA decisions.

Leverage existing authority to increase disclosure and transparency

There is limited transparency into how automated PA systems work and their impact on costs and access to care. Despite having authority to oversee and monitor states' and managed care plans' PA

programs and operations, both CMS and states currently have limited visibility into the adoption and use of automation tools in Medicaid PA. To address this challenge, the following recommendations seek to improve availability of information and data on the use of automation. Improved information and transparency will allow stakeholders to better identify, document, evaluate, and address arising risks associated with the implementation and ongoing use of automation and capitalize more effectively on its benefits.

Recommendation 2.3

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 (42 CFR 438.66), including the external quality review process (42 CFR 438.350) and mandated plan reporting required for Managed Care Program Annual Reports (42 CFR 438.66(e)(1)), can be used to create effective oversight of managed care plans' use of automation in prior authorization.

Rationale

This federal guidance would support states in using existing oversight tools to oversee managed care plans' use of automation, including PA tasks under EQR processes, required appeals and denials reporting for the MCPAR submitted by the state, ongoing managed care monitoring and reporting, and readiness reviews for new managed care contracts. This federal guidance also can recommend that states mandate reporting or other activities that identify the use of and outcomes related to the use of automation in PA under Medicaid managed care contracts.

This recommendation addresses the finding that states have limited insight into managed care plans' use of automation in Medicaid PA. In interviews, no states reported that they have existing or planned mechanisms for collecting data on the use and impact of automation in PA. Absent this information, states are less able to craft informed policy concerning automation in Medicaid PA and are poorly positioned to detect and respond to risks presented by managed care plans' use of automation. A lack of information can also limit states' ability to craft policies that capitalize on the benefits presented by automation.

The recommendation addresses these findings through CMS guidance to states on how they can use existing oversight mechanisms to monitor and oversee managed care plans' use of automation in PA. Examples of the oversight mechanisms this guidance can feature include:

- **Managed care readiness reviews.** State agencies must have an effective monitoring system for all managed care programs under federal regulations (42 CFR 438.66), which include broad-based requirements for monitoring, using monitoring data to improve the managed care program, and readiness reviews for new plans (42 CFR 438.66(b), (c) and (d)). Readiness reviews must include on-site reviews, through which states can require demonstrations of managed care plans' technology platforms, interview UM or IT staff, or otherwise require disclosure and documentation of automation.
- **EQR.** Federal regulations require states to contract with EQROs to conduct regular reviews of managed care plans (42 CFR 438.350–438.370). These reviews must include information on managed care plans' compliance with standards for authorization of services (CMS 2023, 42 CFR 438.358(b)(1)(iii)). Although the EQRO review guidance does not require collection of specific data elements related to UM, or that EQROs assess whether PA denials are clinically appropriate, CMS does develop protocols that states can adopt for interviewing UM staff and assessing UM policies and procedures (CMS 2023). This guidance can include specific examples for states to use, such as model questions or templates included in the EQR protocols.
- **MCPARs.** Federal regulations require states to submit annual reports on their Medicaid managed care programs, known as MCPARs, which includes plan-level data in various program areas. Operationally, states must require plans to report their own data for inclusion in MCPARs and can use contract reporting requirements to specify what must be captured. Currently, MCPARs collect data on appeals and denials at the plan level, but federal policy does not require states to report on the use of automation in PA determinations (42 CFR § 438.66(e)).

CMS guidance can assist states in leveraging these mechanisms to collect information on how managed care plans use automation in the PA process and the impact of PA on their Medicaid programs and beneficiaries. For example, states can use monitoring data to identify the impact of PA on certain services or populations or to identify signs of potential bias in automated PA systems. Some states reported that they lacked the time and resources to develop oversight and monitoring mechanisms and supported CMS issuing guidance on how they can best oversee and monitor managed care plans' use of automation in PA.

The recommendation complements and builds on existing MACPAC recommendations on managed care oversight. In our March 2025 report to Congress, the Commission made recommendations on improving the usability and transparency of findings in the EQR annual technical report. In our March 2024 report to Congress, we made recommendations for CMS to require states to collect and report data on denials and appeals outcomes, report this information in MCPARs, and make the MCPARs publicly available in a format that enables analysis. Finally, in chapter 3 of this report, the Commission issues a recommendation for CMS to develop a publicly available database on managed care plan performance that links federally mandated reported data such as EQR and MCPAR together to facilitate analysis. The data that states collect on automation can be included in such a database and used by states to better understand the impact of automation approaches in different states' programs. Prospective managed care enrollees can also use this database to determine whether managed care plans use automation to process PA requests and if there are any differences in the rate of denials or appeals.

Implications

Federal spending. CBO estimates this recommendation would not have an effect on federal direct Medicaid spending.

States. This recommendation would deliver guidance to states as to how they could structure their current contracts and develop reports to identify the use of and outcomes related to automation in PA as part of existing, required oversight and monitoring activities. It would not mandate that states conduct any additional activities. Implications would vary by state depending on what elements of this guidance they choose to integrate into their practices. States may invest additional resources to conduct these oversight activities, but states would be free to conduct them in a manner that fits within their administrative and financial capacity. State representatives in our interviews reported a lack of information about plans' use of automation as a barrier to effective oversight. States should benefit from the additional transparency and information obtained through these activities.

Enrollees. This recommendation does not directly impact enrollees. Enrollees may benefit if the additional reporting and oversight specific to automation in PA identify potential risks or concerns, such as incorrect adverse determinations, that states and plans can work together to correct.

Plans. This recommendation does not require new reporting elements for managed care plans. As we heard in interviews, some plans may already disclose automation use to states voluntarily. However, states have the flexibility to design and implement disclosure or reporting requirements that vary in breadth or complexity. Managed care plans may incur additional administrative burden to comply with state-determined requirements, such as programming or reconfigurations of reports or demonstrations of system functions.

Providers. This recommendation does not directly impact providers. Providers may experience downstream effects if the additional reporting and oversight specific to automation in PA identify potential issues that lead to changes in PA criteria or processes or improve transparency into payer use of automation.

Recommendation 2.4

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.

Rationale

States should use existing mechanisms to conduct oversight of managed care plans' use of automation in PA. States can report on various performance metrics in a way that allows for ongoing monitoring of outcomes associated with automation in PA, including demonstrations or documentation during readiness reviews, ongoing oversight activities, or contract-required reporting.

This recommendation addresses the finding that states have limited insight into managed care plans' use of automation in Medicaid PA. States hold unique authority to impose contract standards for plan performance and reporting, such as requiring that plans report if and how they use automation in the PA process. States should use this authority to increase visibility into managed care plans' use of automation in PA and to conduct ongoing oversight of managed care plans. Increased visibility can allow states to craft better automation policies and position them to better detect and respond to risks presented by automation.

Implications

Federal spending. CBO estimates this recommendation would not have an effect on federal direct Medicaid spending.

States. States that adopt this recommendation would need to update their managed care contracts and managed care oversight processes to include new requirements, procedures, and reporting related to the disclosure and monitoring of automation in PA. States may need to invest additional resources to achieve these updates, but states would be free to implement them in a manner that fits within their administrative and budgetary capacity. States should benefit from the additional transparency and information obtained through this action.

Enrollees. This recommendation does not directly impact enrollees. Enrollees may benefit if the additional reporting and oversight specific to automation in PA identifies potential risks or concerns, such as incorrect adverse determinations, that states and plans can work together to correct.

Plans. In states that adopt this recommendation, managed care plans will be required to disclose their use of automation and may need to report additional information to states. Managed care plans may incur additional administrative burden to comply with state-determined requirements, such as programming or reconfigurations of reports or demonstrations of system functions. Managed care plans' adoption or applications of automation may be informed by disclosure requirements, leading to increases or decreases in the overall use of automation.

Providers. This recommendation does not directly impact providers. Providers may experience downstream effects if the additional reporting and oversight specific to automation in PA identifies potential issues that lead to changes in PA criteria or processes or improve transparency into payer use of automation.

Looking Ahead

States and managed care plans use automation to streamline the Medicaid PA process and promote appropriate, cost-effective care. The potential benefits of automation impact all stakeholders: it can reduce costs for states and plans, reduce administrative costs and burdens for providers, and lead to faster or easier approvals for beneficiaries. These benefits carry potential risks that automated systems may produce errors and reduce transparency into the authorization decision process for providers and beneficiaries.

The impact and extent of these risks and benefits is still unknown, as there is currently limited information regarding how payers use automation and its impacts on Medicaid PA. The federal government has not, to date, taken concrete steps to address automation in Medicaid PA or to gather more information on its use. States and private sector actors have taken some steps toward monitoring and governance, but this approach varies, and that variation may create barriers to implementing automation. Federal and state action is warranted to establish a clear and agile framework for the use of automation in PA, increase the availability of information on the use of automation, and ensure protections for beneficiaries.

Endnotes

[1] Medical necessity is not defined in Medicaid regulations or statute. In this chapter, "medical necessity" refers to the assessment of whether care is reasonable and needed for the diagnosis, treatment, or prevention of an illness or injury and fits within the scope of a covered Medicaid benefit.

[2] For a more detailed description of the PA process in Medicaid, refer to MACPAC's issue brief on the subject (MACPAC 2024).

[3] An application programming interface is a set of rules that enables software applications to communicate with each other to exchange data, features, and functionality (Goodwin n.d.).

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APPENDIX 2A: State Legislation on Automation in Medicaid Prior Authorization

TABLE 2A-1. State Laws Affecting Automation in Medicaid Prior Authorization

State	Law	Date passed	Relevant text
Arizona	H.B. 2175	May 12, 2025	Health insurers cannot use AI to deny claims or PA requests; a licensed health care provider must individually review each denial.
California	S.B. 1120	September 28, 2024	AI and algorithms cannot replace health care provider decision making. Any AI or algorithm used in utilization review must rely on the patient's individualized clinical information, and all final approvals and denials must be made by a licensed, clinically competent provider. Plans must ensure AI tools are applied equitably (no bias or discrimination), maintain and disclose written utilization review policies, comply with privacy laws, and remain subject to oversight.
Illinois	H.B. 2472	July 19, 2024	Appeals of automated denials must be reviewed by a qualified clinical peer clinician (not left to automation). Any automated denial process must use objective, evidence-based criteria accredited by a recognized body, such as the National Committee for Quality Assurance.
Indiana	S.B. 480	May 1, 2025	Utilization review entities are required to publish PA requirements online, provide approval and denial statistics, and explain denials or modifications. This law, effective July 1, 2025, excludes fee for service. The state is currently conducting an analysis of its impact on managed care.
Maryland	H.B. 820	May 20, 2025	An AI-based algorithm cannot be the sole basis for denying, delaying, or modifying care based on medical necessity. Payers and pharmacy benefit managers using AI must ensure determinations are based on individual clinical information, not solely group data sets; comply with clinical standards; not replace provider judgment; avoid discrimination; undergo oversight and audits; and be reviewed quarterly for accuracy. AI tools cannot deny, delay, or modify health care services.

TABLE 2A-1. (continued)

State	Law	Date passed	Relevant text
Nebraska	L.B. 77	June 4, 2025	An AI-based algorithm cannot be the sole basis for denying, delaying, or modifying care based on medical necessity. All adverse determinations must be made by a physician or clinical peer. Utilization review entities must disclose to the Department of Insurance, providers, and enrollees and on their public website whether AI is used in PA decisions. The Department of Insurance may audit automated utilization systems, and carriers must annually report PA data (e.g., requests, denials, appeals, and top reasons for denials).
Texas	S.B. 815	June 20, 2025	Utilization review agents are prohibited from using algorithms, AI systems, or automated decision systems to make adverse determinations about medical necessity or coverage (only human reviewers can issue such denials). The insurance commissioner is allowed to audit automated system use. AI may still be used for administrative support or fraud detection.

Notes: AI is artificial intelligence. PA is prior authorization. Minnesota (H. 2500), Pennsylvania (H.B. 1663), and Washington (S.B. 5395) have pending legislation on this topic.

Sources: MACPAC and Mathematica 2025 policy reviews of legislation on automation in the PA process.

APPENDIX 2B: Uses of Automation in the Medicaid Prior Authorization Process

TABLE 2B-1. Uses of Automation in Medicaid Prior Authorization

Steps in the PA process	Pain points	Example automation solutions
Health care provider determines item or service is needed for treatment and places order	• Difficulty keeping track of which services require PA across multiple payers	• Predict future appropriate care settings to expedite PA decisions (predictive AI and algorithms, using clinical data)
Provider contacts Medicaid FFS program or MCO to determine PA requirements	• Complexity and variation in PA rules across payers • Time-intensive manual lookup of requirements	• Identify which services require PA based on payer-specific necessity requirements (deterministic rules-based AI and algorithms, linked to Medicaid or MCO clinical criteria) • Navigate large coverage documentation files to determine coverage (NLP and AI chatbots)
Provider submits required documentation	• Burden of collecting and formatting patient data in correct form • Manual process of submitting required documentation	• Extract structured data from the electronic health record and other sources to fulfill documentation requirements (NLP) • Use generative AI to draft the PA request
FFS program or MCO reviews PA request	• Manual review is time consuming and error prone	• Triage requests to the appropriate reviewer (machine learning) • Extract and classify relevant information from PA documentation (NLP) • Identify requests that can be automatically approved by comparison to established algorithms and clinical criteria (rules-based algorithms) • Flag potential erroneous or fraudulent PA submissions (rules-based algorithms)

TABLE 2B-1. (continued)

Steps in the PA process	Pain points	Example automation solutions
FFS program or MCO issues PA decision, resulting in an approval or denial (which may result in denial appeal)	• Delays in communicating decisions to providers and patients • Lack of clarity for denial reason • Time-intensive appeals process for providers and patients • High rates of overturned denials because of process inefficiencies	• Generate draft denial rationales or approval notices to beneficiary (generative AI)

Notes: PA is prior authorization. AI is artificial intelligence. FFS is fee for service. MCO is managed care organization. NLP is natural language processing.

Sources: MACPAC 2024 and Mathematica 2024 literature and federal policy reviews of the policies, legislation, and regulations that govern automation in the PA process.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on May 7, 2026.

Automation in Medicaid Prior Authorization

2.1 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; (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

2.1 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

2.2 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, 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.

2.2 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

2.3 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 (42 CFR 438.66), including the external quality review process (42 CFR 438.350) and mandated plan reporting required for Managed Care Program Annual Reports (42 CFR 438.66(e)(1)), can be used to create effective oversight of managed care plans' use of automation in prior authorization.

2.3 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

2.4 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.

2.4 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	