Prior Authorization in Medicaid: Issue Brief 1 – Prior Authorization and the Critical Need for Reform

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Introduction

This issue brief series explores how prior authorization policies shape access to care in public health coverage programs, particularly Medicaid. The first brief introduces the fundamentals of prior authorization, how it operates for Medicaid beneficiaries, and the growing movement for reform. Future installments will explore the legal and policy implications of prior authorization, highlight emerging reform efforts at both the federal and state levels, and identify advocacy strategies to promote transparency and accountability in Medicaid.

Overview of Prior Authorization

Prior authorization (PA) is a process where an insurance company (payer) approves and covers a service, item, or medication, only after the plan determines it is medically necessary. While intended to control costs and promote "appropriate" care, PA represents one of the biggest barriers to timely treatment and one of the largest administrative hurdles in our health care system. Beneficiaries often wait weeks for decisions, including approvals, even if urgent care is needed, or they receive denials that are confusing and hard to appeal.[1]

More than 15 percent of all insured adults experienced problems with PA in 2023.[2] That number increases for adults who needed more health care services or needed specific services, like treatment for chronic conditions (31 percent had issues), treatment for mental health conditions (26 percent), emergency room visits (25 percent), and prescription drugs (19 percent).[3] Importantly, those who had difficulty with PA were also much more likely to experience other insurance problems and barriers to health care, including higher out-of-pocket costs, limited provider networks, treatment limits, and lack of coverage for needed services.[4]

The Prior Authorization Process

Typically, a provider initiates a PA request for a service, item, or medication and includes details explaining the need. This request usually, though not always, happens electronically through a standardized form. The plan then reviews the request and issues a decision about whether the service, item, or medication is medically necessary; whether it is the appropriate service to address the issue; whether an alternative service is equally safe and effective but less costly; whether a coverage limit has been reached; and whether the plan covers the service. Typically, payers state that a medical clinician reviews the request and decides

whether the item or service is a medical necessity, but these reviews can also occur algorithmically or via individuals with more limited or less relevant experience. State rules may limit the use of algorithms, stipulate what level of clinical expertise reviewers must have, set time limits for plan decisions, or otherwise limit PA. Still, even urgent services commonly face processing delays and improper denials.

In some cases, the plan asks for a "peer-to-peer" discussion where the treating clinician who ordered the service or medication speaks with a plan clinician directly. These meetings can resolve questions but can also slow things down. Ongoing care may also face "concurrent review," where an initial PA approval covers only a set period of time and extensions must be approved. Even with an approval, payment is not guaranteed. Plans sometimes still deny after the fact if the billed service or documentation does not match what the plan initially approved. These are called "retrospective denials."[5]

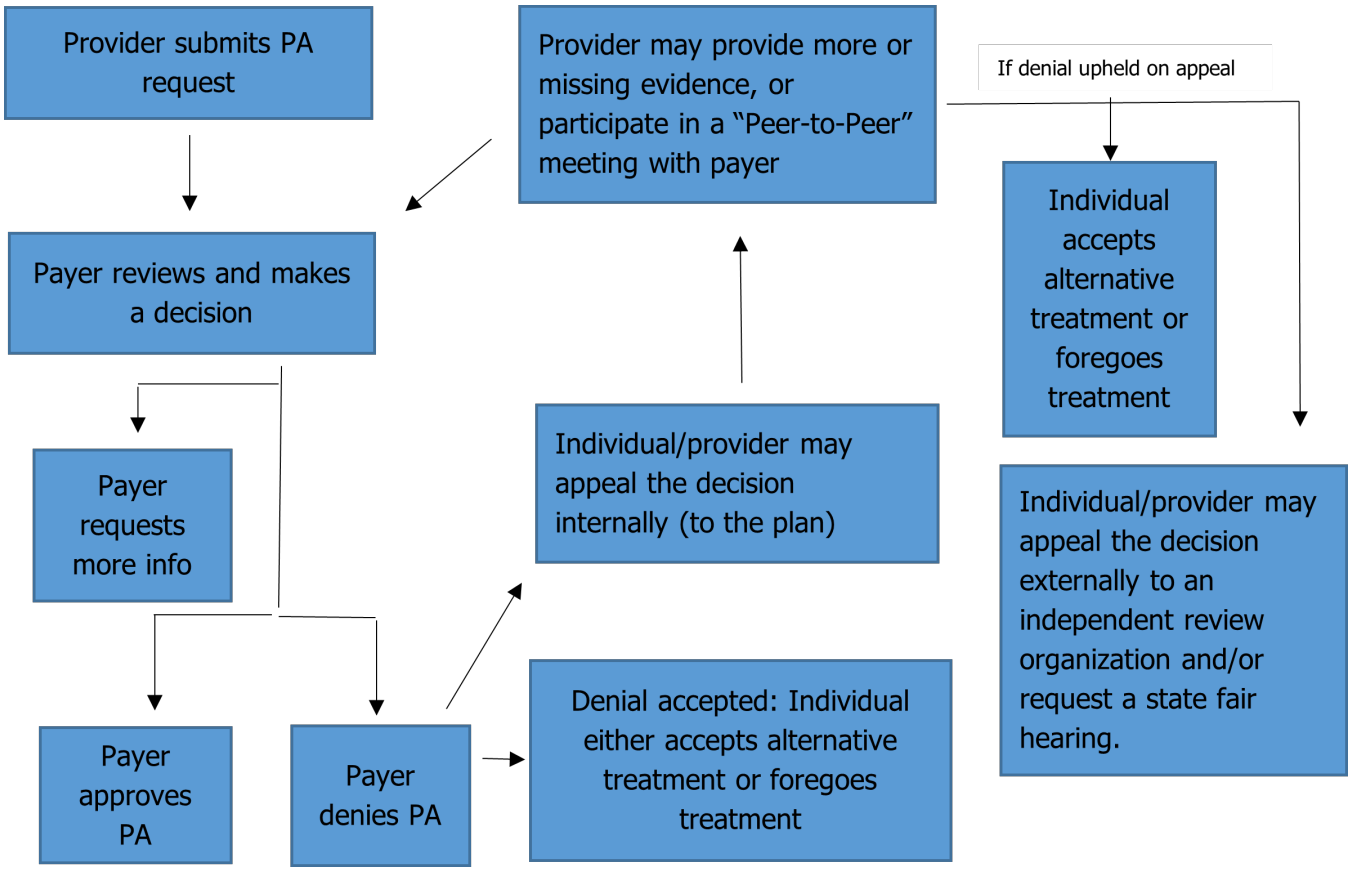
Individuals may appeal denials of PA, but the processes vary depending on state laws, regulations, and plan type. Typically, an appeal starts through the plan's internal process and requires the treating clinician to compile supporting documentation and meet very specific deadlines. If denied again, an individual may be able to access an external review, usually by an independent third party. Finally, if all else fails, individuals enrolled in Medicaid maintain due process rights and may seek legal recourse for denials through state fair hearings.

While the PA process for prescription drugs is mostly the same, the pharmacy (rather than the treating provider) typically flags PA when needed and works with the prescriber to make the request. The payer may also have formularies or preferred drug lists, which are drugs covered without PA; "step therapy" rules that require trying a preferred drug first; and quantity limits before another PA is required.

Historically, PA decisions have not been portable and are time limited. When a beneficiary switches plans or providers, or needs updates to an existing prescription like a dosage adjustment, existing approvals usually disappear, forcing individuals and providers to start over (even mid-treatment). The same is true for people who need continued care for chronic conditions – typically, approvals expire.

Individuals across the country have suffered from this lengthy process. Cancer patients have had to file a PA request for each round of chemotherapy and others have been denied life-extending treatment.[6] In Virginia, one young woman with small fiber neuropathy faced denial of an expensive blood treatment that would ease her almost constant pain. When her plan claimed the therapy was not "medically necessary," her parents withdrew tens of thousands of dollars from their retirement savings to cover the cost.[7] Stories like these are far too common.[8]

Figure 1: Typical Prior Authorization Process*



*This chart reflects a typical managed care process. Processes may differ by plan or program. For example, Medicare Advantage requires an automatic external medical review after the internal appeal. [9]

The PA process is no less burdensome for providers. The time and staffing required to manage PA requests are staggering. Forty percent of physicians have hired staff that work exclusively on PA, while the rest spend on average 13 hours each week navigating PA-related work.[10] As a result, physicians report they are less available to their patients.

Detailing the Harm

Studies and federal oversight reports have found that payers systematically deny care through PA, as most patients will not appeal denials. In a review of Medicaid MCOs, only 11 percent of individuals who received a denial requested an internal review (or appealed) and from there, only 2 percent were appealed to a state fair hearing process.[11]

Two OIG reports on Medicare Advantage plans and a Medicaid managed care plan in Pennsylvania, respectively, found that plans denied services using clinical criteria for PA approval that were not appropriate under program rules.[12] Recent federal investigations documented widespread reliance on reviewers who lack relevant clinical expertise and on third-party automated systems that prioritize efficiency over individualized reviews.[13] One

former Cigna medical director came forward with a troubling example and said the company pressured doctors to rush through claim reviews and deny care without fully looking at patient's medical records.[14] These practices directly contribute to unnecessary denials that can lead to delays (when appealed) and worsening health outcomes.

These studies also found that plans used inappropriate clinical criteria for denials and many states did not require regular review of denials for the appropriateness of clinical criteria.[15] In one instance, OIG reviewers found that Medicare Advantage plans sometimes required an enrollee to have an X-ray before they would approve more advanced imaging, such as an MRI or CT scan, even though Medicare coverage rules do not require that step.[16]

Sometimes a plan denies services not based on the diagnosis but based on the urgency of the need or a requirement for patients to first try cheaper (and perhaps less effective) services ("step therapy"). A North Carolina man battling severe depression and suicidal thoughts was denied life-saving mental health care by Highmark Blue Cross Blue Shield, which claimed his month-long inpatient treatment was not "medically necessary," and that less intensive therapy and medication would be enough.[17] His physician appealed, arguing that "based on the indisputable facts, we are unsure why anyone would assert that any part of the insured's inpatient behavioral health treatment was 'not medically necessary.'" His partner appealed through an external review, but the plan said his denial was not eligible for the review. Weeks later, after his physician prescribed an antidepressant and antianxiety medication, he had a panic attack that resulted in an emergency room visit. The plan eventually agreed to pay for a week of the treatment ($10 thousand a week), but after another denial for the remaining three weeks, his wife appealed through another external review. This time, the human reviewer agreed that treatment was necessary.

Frequently, utilization management (UM) vendors use algorithms and artificial intelligence (AI) to route requests and decisions, populate records and forms, and even make recommendations about medical necessity. A recent nationwide survey of health insurers by NAIC found that most carriers already use AI tools somewhere in their operations, and many use it in PA. Across individual and group markets, roughly two-thirds to three-quarters of plans report using AI to support PA approvals, which can speed up the process of approvals. A smaller, but notable share (about 8–12%) use AI to support PA denials. [18]

The harm from these delays cannot be overstated; for many patients, they are deadly. When L.J. Cupp started showing signs of serious heart trouble, his doctor ordered a heart catheterization to check for blockages.[19] United HealthCare, through its contractor, EviCore, denied it as "not medically necessary." Even after a second request, they refused. Nearly three months later, Cupp was finally approved for a cheaper test that revealed his heart was even weaker. The next day, Cupp went into cardiac arrest and died.

Figure 2: Physicians Agree that PA is Inefficient and Harms Patients[20]

The American Medical Association has consistently documented the harms associated with prior authorization. According to a 2024 AMA provider survey:

- 93% of physicians reported that PA causes delays in care.
- Nearly 90% described the burden of PA as "high" or "extremely high."
- 82% said PA can lead to patients abandoning treatment due to the burden.
- 1 in 4 physicians reported that prior authorization has led to a serious adverse event for a patient in their care, including 23% who said it led to a patient's hospitalization.

Even when PA requests are approved, physicians still report that the process itself is a burden and harms care. One physician explained: "The maddening duties of prior authorization disconnect us from our daily clinical flow and impede our delivery of care… My nurse was denied a prior authorization request, and a peer-to-peer contact was requested of me with the insurance company. My return call for the peer-to-peer that evening was unsuccessful as they had left after 4:30 p.m. I called the next day—and after being on hold for several minutes—I gave the same information was delivered to the insurance company the day before. I was immediately given the authorization. The decision seemed to be predetermined without me giving any more information… I explained to [the reviewing physician] that during a prior authorization, much of a physician's time is wasted."

Prior Authorization in Medicaid: Before 2024 Federal Reforms

PA impacts Medicaid beneficiaries more than any other insured group. In 2023, 1 in 4 adults enrolled in Medicaid reported problems with PA in 2023 – a higher rate than the 16 percent of adults enrolled in Medicaid, Medicare, or Marketplace plans who reported problems.[21] PA barriers especially affect people with disabilities and chronic conditions, including 25 percent of adults who seek treatment for mental health conditions.[22] Among adults who experienced PA problems, a staggering one in three could not get the care their provider recommended.[23] One in 4 who had problems experienced a decline in health as a result of these hurdles.[24]

Medicaid Managed Care Organizations (MCOs) control access to care for over 75 percent of Medicaid beneficiaries, and they use PA extensively.[25] In Medicaid, both state agencies (for fee-for-service programs, or FFS) and MCOs decide which services require PA. Common targets include non-emergency medical transportation, durable medical equipment (DME), behavioral health services, inpatient hospital stays, surgeries, rehabilitation services, nursing facility care, and prescription drugs. Federal law prohibits PA from being used to deny screening services for children and youth (EPSDT services).[26] However, if a child's physician recommends a specific treatment for a child, for example: intensive behavioral health services or private duty nursing; under law, the state or MCO may allow PA to determine medical necessity, but it cannot deny or delay the service.[27]

Before a 2024 federal rule (explained in Issue Brief #2), decision timelines were relatively loose: Medicaid FFS payers did not have any timelines, unless the state regulated them. Medicaid MCOs had up to 14 days to process standard PA requests and 72 hours for urgent requests.[28]

Oversight agencies investigated and revealed how problematic and widespread the use of PA had become. A 2022 OIG audit of Keystone First (an MCO) found that in a 2-year period the plan denied more than 136 thousand PA requests, with 76% of a sample of denials deemed improper, most commonly for missing documentation, and many failing to notify beneficiaries of appeal rights.[29] As one example of "missing" documentation, Keystone First denied pediatric skilled nursing, including overnight care, to at least 10 caregivers (out of a sample of 100) who could not show they were working or in school.[30] In 2023, a Congressional request prompted the HHS Office of the Inspector General to conduct a broader review of PA delays in Medicaid. The report revealed that the largest 115 Medicaid MCOs denied more than 2 million of the 17 million PA requests – plans had denial rates above 25 percent.[31]

In response, in January 2024, the Centers for Medicare & Medicaid Services (CMS) published the "Interoperability and Prior Authorization Final Rule" ("Rule").[32] The Rule takes steps to "improve prior authorization processes through policies and technology, to help ensure that patients remain at the center of their own care."[33] It promises faster decisions, clearer denial notices, and more transparency, while also beginning a shift toward electronic systems. The Rule also goes beyond regulating PA processes and attempts to simplify the exchange of health information so that patients, providers, and health plans can get the records they need, when they need them. Most provisions go into effect on January 1, 2026, offering an opportunity to see how these reforms function in practice and identify any unintended effects.

Debunking Justifications for Prior Authorization

Proponents of PA often claim that it helps to reduce the overuse or misuse of services, and controls the rising cost of medical care. But the evidence of its negative impacts on patients and providers counteracts these claims, and even suggests the process mainly helps insurers boost their bottom lines. The use of PA consistently reduces access to care, denies and delays medically necessary services, is administratively burdensome on patients and providers, and expensive to administer.[34]

In the case of pharmaceutical PA, one pharmacist said that in some cases, "a prescription may be written for a costly brand name drug that has a therapeutically equivalent generic version available" as "providers may not have been initially aware of the available alternatives..."[35] This individual cited to just one example: a proposed PA program in Utah for opioid medication that included dosage limits and step therapy and seemingly saw a decrease in overall use and cost." However, this completely ignores worsened patient outcomes, for example where a generic drug may cause an adverse reaction or be less effective.[36] The same study also recognized that the policy "could lead to a portion of patients that may not receive treatment due to the cost and hassle of doctors undergoing the prior authorization process" and "[t]he

costs of opioid medications would likely be too high for many patients to afford on their own, unfairly disadvantaging poor patients."[37]

In reality, one of the most common reasons for a PA denial is a lack of appropriate documentation.[38] One physician recognized the rising costs of health care, but emphasized its use for standard treatments: "it seems like there is no rhyme or reason to [requiring prior authorization] because it's not just for new or expensive medications." Another physician added: "We are all very trained to deliver… care in very narrow specialties. If we believe a test or procedure is important, that is generally because it is concordant with guidelines."[39] Helpfully, CMS issued a rule in 2024 that, among other requirements, says that plans must provide clear guidelines for the documentation required to approve a PA request.[40]

Conclusion

As numerous studies, reports, and patient stories make clear, prior authorization rarely benefits patients or providers. More often, it stands between people and the care a doctor has said is needed, creating delays, adding administrative costs, and real consequences for patients' health. Fixing prior authorization starts with one simple idea: the system must center people and their health outcomes above every other goal.

Stay tuned for Issue Brief #2 in the series, which will cover the requirements of the 2024 Interoperability and Prior Authorization Final Rule.

ENDNOTES

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