Prior Authorization in Medicaid: Issue Brief 2 – Federal Oversight of Prior Authorization

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I. Introduction

Prior authorization (PA) is a utilization management tool where a payer (often an insurance company) approves and covers a service, item, or medication only after determining it is covered and medically necessary. While proponents claim PA controls costs and promotes appropriate care, this practice represents one of the biggest barriers to timely treatment. Beneficiaries often wait weeks for decisions, even if care is urgently needed, and then they may receive denials that are confusing and hard to appeal.[1] Physicians, advocates, beneficiaries, and politicians from both sides of the aisle have raised serious concerns about prior authorization and called for reform. In this issue brief, we will discuss recent federal regulations that govern the use of prior authorization across Medicaid and many payers.

Following several concerning industry reports about prior authorization more broadly, Congressional requests prompted two federal agencies to review prior authorization outcomes in Medicaid. A 2022 HHS Office of Inspector General (OIG) audit of Keystone First, a Medicaid MCO in Pennsylvania, found that 76% of a sample of denials were deemed improper, most commonly for missing documentation, and many failing to notify beneficiaries of appeal rights.[2] In 2023, another Congressional request prompted OIG to conduct a broader review of prior authorization delays in Medicaid. The analysis revealed that the largest 115 Medicaid MCOs denied more than 2 million of the 17 million prior authorization requests – 12 plans had denial rates above 25 percent.[3]

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[1] Medicaid & CHIP Payment & Access Comm'n (MACPAC), Prior Authorization in Medicaid 1–3 (Aug. 2024), https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf.

[2] U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., Keystone First Did Not Always Comply with Federal and State Requirements for Denying Prior Authorization Requests (Dec. 20, 2022), A-03-20-00201, https://oig.hhs.gov/oas/reports/region3/32000201.asp.

[3] U.S. Dep't of Health & Human Servs., Office of Inspector Gen., High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care (July 2023), OE-01-19-00350, https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.

In response to these findings, in January 2024, the Centers for Medicare & Medicaid Services (CMS) published the "Interoperability and Prior Authorization Final Rule" ("Final Rule").[4] The Rule attempts to "improve prior authorization processes through policies and technology, to help ensure that patients remain at the center of their own care."[5] It also goes beyond regulating PA processes and timelines, and attempts to simplify the exchange of health information so that patients, providers, and health plans can get the records and information they need, when they need them.

II. Who and What the Interoperability & PA Final Rule Covers

The Rule applies to "services and items" provided by most publicly funded health insurance programs, including:

- Medicaid fee-for-service (FFS) and managed care (MCOs),
- the Children's Health Insurance Program (CHIP),
- and Medicare Advantage (MA) plans.

The Rule also applies to Qualified Health Plans on federally facilitated exchanges (QHPs). Each requirement does not apply consistently across payer type. These differences are explained in more detail below.

Importantly, the Rule does not apply to prescription drugs. It also does not apply to Medicare FFS (traditional Medicare) or private plans that are not QHPs (for example employer-sponsored health plans).

III. Key Provisions of the Rule

Timelier Decisions (Jan. 1, 2026)

The Final Rule establishes a federal baseline for how quickly payers must decide PA requests. These timeline restrictions apply to medical items and services only, not prescription drugs. Beginning January 1, 2026, Medicaid FFS agencies, Medicaid MCOs, and CHIP programs must now make determinations as expeditiously as the enrollee's condition requires and in no case later than seven calendar days for a standard request.[6] For expedited requests, where delay could "seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain

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[4] *Medicare & Medicaid Programs: Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes,* 89 Fed. Reg. 8,534 (Feb. 8, 2024).
[5] *Patient Access and Interoperability Final Rule*, 89 Fed. Reg. 8758 (Feb. 8, 2024) (to be codified at 42 C.F.R. §§ 422, 431, 438, 457 & 45 C.F.R. § 156).
[6] *See* 42 C.F.R. § 431.201, 437.210(d), 457.1230 (2024); *Patient Access and Interoperability Final Rule*, 89 Fed. Reg. 8758 (Feb. 8, 2024)

maximum function," payers must decide within seventy-two hours or as expeditiously as the enrollee's health requires. States may permit an extension of up to 14 days only when justified, such as when additional documentation is needed. In those cases, payers notify the beneficiary of the reason for delay and their appeal rights. This regulatory floor replaces the patchwork of state-specific standards that often allow for longer decision timeframes. Even better, for Medicaid FFS, the federal floor is still subject to state laws that require shorter timeframes. In other words, if a state requires approval for standard requests in three days for its Medicaid FFS program, the timeline is three days, not seven.

For MA organizations, CMS similarly requires that PA decisions for items and services subject to 42 C.F.R. § 422.122 be made "as expeditiously as the enrollee's health condition requires, but no later than seven (7) calendar days." However, unlike Medicaid and CHIP, the Final Rule does not establish a universal 72-hour expedited timeframe for MA.[7]

The Final Rule does not impose any decision timeframes on QHPs in the ACA marketplaces.[8] QHPs remain subject to applicable state laws or plan-specific standards.

All together, these updates establish a clearer federal baseline: by next year, most Medicaid, CHIP, and Medicare Advantage beneficiaries should see faster, more predictable PA decisions.

Public Reporting (Jan. 1, 2026 and annually)

Beginning in 2026, nearly all major payer types (MA, Medicaid FFS and MCOs, CHIP programs, and QHPs) must begin publicly reporting data on their PA practices. These reports are required annually and must be published by March 31 on a public-facing website. Reports must include:

- A list of all items and services that require PA,
- The aggregate percentage of standard PA requests approved,
- The aggregate percentage of expedited PA requests approved,
- The aggregate percentage of standard PA requests denied,
- The aggregate percentage of expedited PA requests denied,
- The aggregate percentage of standard PA requests approved after appeal (not expedited),
- The aggregate percentage of requests for which the timeframe for review was extended and the request was approved, and
- The average and median time between submission and determination for standard; expedited.[9]

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[7] *See* 42 C.F.R. § 422.568(g)(1)(ii)(A) (2024); 89 Fed. Reg at 8864-66.
[8] *See* 45 C.F.R. § 156.136 (2024); 89 Fed. Reg. at 8880.
[9] 42 C.F.R. §§ 422.119(I), 431.70, 438.242, 457.430, and 156.331 (2024); 89 Fed Reg. 8758 (Feb. 8, 2024).

The reporting requirements are intended to create transparency and allow beneficiaries, advocates, and regulators to compare how payers use PA and how quickly they can make determinations. However, because CMS only requires aggregate information, without breakdowns by service type or population, stakeholders will be unable to see variation in denial rates. Specifically, high denial rates for an expensive but uncommon service could be rendered effectively invisible. CMS explained that they considered disaggregated data, but "believe that reporting detailed service-level or procedure-level data would present significant confidentiality, data-system burden, and consistency challenges that could impede timely public reporting…" noting that "the standardization of service-level identifiers across payers is not yet mature enough to support consistent public reporting at the procedure-code level."[10]

Despite this limitation, this is the first time that consistent, cross-program data on PA will be publicly available. This data is an important start to the collection and publication of information that beneficiaries can use to identify which plan is best for them and that advocates can use to hold payers accountable.

Explanations for Denials (Jan. 1, 2026)

Beginning January 1, 2026 all covered payers under the Final Rule must give the provider a specific reason when denying a PA, regardless of how the denial communication takes place.[11] In the past, many PA denial notices simply stated that the service or item was "not medically necessary" or "criteria not met," which made it difficult for beneficiaries and their providers to challenge or correct.

The Rule does not say exactly what evidence is required, but the preamble guidance explains CMS's expectation the information should be useful "to the provider to decide next steps, such as re-submitting the request with updated information, identifying alternative treatments for the patient, or appealing the decision."[12]

Electronic PA and Data Sharing (Jan. 1, 2027)

The Final Rule requires impacted payers to create new electronic workflows and application programming interfaces (APIs) to modernize the PA process and make the exchange of health information more widely available. An API works like a secure bridge that allows two computer systems to exchange information directly. These will allow providers to upload PA requests and documentation more easily and enable plans to process PA requests and communicate decisions and approval criteria electronically, rather than through paper forms or a patchwork of different systems.

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[10] 89 Fed. Reg. at 8890.
[11] 42 C.F.R. §§ 422.568(g)(1)(ii); 43.201; 438.210(b)(3); 157.1230; 156.136.
[12] 89 Fed. Reg. 8758, 8877-78 (Feb. 8, 2024).

By January 1, 2027, all payers subject to the new rule must:

1. **Expand their Patient Access API** to include the following PA data (excluding drugs): request status, decision date, expiration date/reason, items or services approved, and the reason for denial. Importantly, the API must include "related structured administrative and clinical documentation submitted by a provider."[13]
2. **Implement a Prior Authorization API** that supports HIPAA-compliant electronic requests and responses. The API must include: a list of the plan's covered items and services requiring PA, all documentation required for obtaining an approval, the ability to communicate approvals, denials, or requests for additional information, the specific reason for any denial, and the date or circumstance when an approval ends. Updates to a beneficiary's PA status must be made within 1 business day of receipt of the request or status change and must be retained for at least 1 year after the last change. Note: Medicaid state agencies can request an exemption for this API if 90 percent of enrollees are in MCOs, as long as providers have access to the information in another way.[14]
3. **Establish a Provider Access API** to make PA information accessible to in-network providers for treatment and care coordination.[15]
4. **Establish a Payer-to-Payer API:** that allows exchange of PA data between payers when an enrollee changes coverage (with enrollee consent).[16]

In July 2025, CMS issued a Relevant Standards and Implementation Guide for these APIs.[17]

Appeal Rights, Due Process, and Enforcement

The Rule does not create an enforcement scheme for PA. Instead, CMS confirms that each program will enforce the requirements under existing authorities. This means oversight, corrective actions, and penalties will continue to vary by program. In the preamble, CMS explained that "[e]ach CMS program oversees compliance under existing program authorities…

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[13] *See* 42 C.F.R. §§ 422.119(b)(3)(ii), 431.70(b)(3), 438.242(b)(3), 457.730(b)(3), 156.221(b)(3) (2024); 89 Fed. Reg. 8758 (Feb. 8, 2024).
[14] *See* 42 C.F.R. §§ 422.119(k), 431.70(k), 438.242(k), 457.730(k), 156.221(k) (2024); 89 Fed. Reg. 8758 (Feb. 8, 2024).
[15] *See* 42 C.F.R. §§ 422.119(c), 431.70(c), 438.242(c), 457.730(c), 156.221(c) (2024); 89 Fed. Reg. 8758 (Feb. 8, 2024).
[16] *See* 42 C.F.R. §§ 422.119(e), 431.70(e), 438.242(e), 457.730(e), 156.221(e) (2024); 89 Fed. Reg. 8758 (Feb. 8, 2024).
[17] Centers for Medicare & Medicaid Servs., *Application Programming Interfaces (APIs) & Relevant Standards & Implementation Guides (IGs)*, CMS (July 29, 2025), https://www.cms.gov/priorities/burden-reduction/overview/interoperability/implementation-guides-and-standards/application-programming-interfaces-apis-and-relevant-standards-and-implementation-guides-igs.

Oversight and compliance procedures and processes vary among these programs, and CMS may choose from an array of possible enforcement actions, based on a payer's status in the program, previous compliance actions, and corrective action plans."[18] This is concerning as both OIG and MACPAC have emphasized that accountability rests on better data auditing and expanded external review opportunities.[19] MACPAC and OIG audits of samples of prior authorization requests found inappropriate use of criteria, insufficient notices, and evidence of systemic denials with low appeal rates.[20] State oversight of MCOs is also falling short.[21]

The Rule, however, does strengthen beneficiary due process protections within the Medicaid and CHIP programs. CMS amended 42 C.F.R. § 431.201 to clarify that previously approved prior authorization denials meet the definition of "action," confirming that "beneficiaries are afforded due-process protections, such as notice and the opportunity for a fair hearing, when coverage that was previously approved through a prior authorization process is later discontinued or reduced."[22] This explicitly aligns some prior authorization denials with other adverse benefit decisions. For Medicaid MCOs, the existing appeal and grievance provisions apply, meaning beneficiaries retain rights to both plan appeals and, after exhausting plan appeals, state fair hearings.[23]

IV. Issues for Future Reform

Prior to the Rule, CMS also asked for public input on several additional reforms that, despite broad support, were ultimately not finalized:

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[18] 89 Fed. Reg. at 8764.
[19] Medicaid & CHIP Payment & Access Comm'n (MACPAC), Prior Authorization in Medicaid 1–3 (Aug. 2024), https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf; U.S. Dep't of Health & Human Servs., Office of Inspector Gen., High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care (July 2023), OE-01-19-00350, https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.
[20] *See, e.g.*, U.S. Dep't of Health & Human Servs., Office of Inspector Gen., High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care (July 2023), OE-01-19-00350, https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.
[21] Daniel Young, National Health Law Program, *Managed Care Sanctions: An Important Tool for Accountability* (July 30, 2025), https://healthlaw.org/resource/revisiting-managed-care-sanctions/.
[22] *See* 42 C.F.R. § 431.201 (2024), 89 Fed. Reg. at 8870-73.
[23] *Id.*; 42 C.F.R. § § 438.400-.424

- Expansion of reforms to prescription drugs, where PA is widely used and continues to expand.[24] Beneficiaries disproportionately face significant barriers accessing needed medications due to PA.
- Stronger reporting requirements that go beyond aggregated data, including appeals outcomes, with breakdowns by service, provider, and beneficiary characteristics.
- Real-time or instant PA **approval** decisions for some services, which many commenters requested.
- Standardized technology across all payers. CMS opted not to create one, national electronic data system saying it stifles innovation and likely goes beyond statutory authority.
- Longer validity periods for approved authorizations. Many commentors requested minimum durations, for example 12-month approvals or longer, to protect continuity of care for individuals with chronic conditions or disabilities
- Continuity of care when changing coverage. CMS sought comment on requiring payers to honor active prior approvals when a beneficiary transitions between plans or programs. Although the Rule includes a payer-to-payer API to facilitate the transfer of data in this instance, it stops short of mandating that new payers accept current approvals from prior payers. Alternatively, new payers could be required to allow beneficiaries to transfer existing approvals to a new plan or program.
- Exemptions for providers with a history of high approval rates ("gold-carding), which give special treatment to certain providers, but can lead to inequitable access to services while leaving the larger issues with PA in place.
- Exemptions for services and procedures with a history of high approval rates (also often referred to as "gold-carding"), improving access for all enrollees and reducing burden across the entire system.
- Stronger denial notices and appeal standards. CMS agreed that notices should be clear and actionable, but finalized only the requirement that each denial includes a specific reason. The Rule does not strengthen or add any new PA-specific requirements to existing PA appeals processes, such as requiring independent review for decisions upheld on internal appeal in Medicaid or ending the requirement to exhaust internal appeals.
- Stronger enforcement mechanisms to ensure compliance.

[24] Grace Sparks et al., KFF, *KFF Health Tracking Poll Public Finds Prior Authorization Process Difficult to Manage* (July 25, 2025), https://www.kff.org/patient-consumer-protections/kff-health-tracking-poll-public-finds-prior-authorization-process-difficult-to-manage/; American Medical Assoc., *Have Payers Changed their Tune on Prior Authorization? AMA Survey Says Nope* (Aug. 5, 2024), https://www.ama-assn.org/practice-management/prior-authorization/have-payers-changed-tune-prior-auth-ama-survey-says-nope.

V. Industry Response

A year after the Final Rule, AHIP, the national trade association representing the health insurance industry, and the Blue Cross Blue Shield Association announced a set of "voluntary commitments" to "streamline" PA and "improve patient outcomes."[25] Major insurers including Aetna, Centene, Cigna, Elevance Health, Humana, and UnitedHealthcare signed on. These commitments suggest that insurers are putting more guardrails on themselves regarding PA use. In reality, though, the guardrails largely repeat existing obligations under the Rule.

For example, the pledge to adopt FHIR-based technology for electronic submission by January 1, 2027, is not new. That deadline is already mandated under the Rule for many plans. Likewise, the promise to improve transparency by explaining denials in plain language and providing appeal guidance simply restates baseline requirements found in the Rule.

While some commitments mirror existing requirements that lend a degree of accountability (if enforced), other so-called "new" commitments rely entirely on voluntary compliance and lack meaningful oversight. For example, a pledge to reduce PA volume by 2026 only "as appropriate" for each plan's local markets lets insurers set their own goals and change them without consequence.

Another commitment – to have clinicians review denials – is described by AHIP as an industry-wide "existing norm." Even if that is true, there is no standard requiring plans to disclose who is making decisions or what relevant experience these clinicians have in the field.

These same corporations made similar promises in 2018 and again in 2023.[26] At the time, they vowed to reduce PA and increase transparency. But without any enforcement, those promises went nowhere and the volume of prior authorization increased.[27] This is especially true for

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[25] AHIP, *Health Plans Take Action to Simplify Prior Authorization* (June 23, 2025), https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization.

[26] *See* Am. Med. Ass'n et. al., *Consensus Statement on Improving the Prior Authorization Process* (Jan. 18, 2018), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf; *Health Insurers Promise Changes to Prior Authorization Process – What to Know,* NBC News (June 23, 2025), https://www.nbcnews.com/health/health-news/kennedy-says-health-insurers-promise-change-prior-authorization-proces-rcna214515.

[27] *See* Andis Robeznieks, *In 2018 Payers Agreed to Rein in Prior Auth. The Clock is Ticking*, Am. Med. Ass'n (June 10, 2022), https://www.ama-assn.org/practice-management/prior-authorization/2018-payers-agreed-rein-prior-auth-clock-ticking; Am. Med. Ass'n, *2024 AMA Prior Authorization Physician Survey* (2024), https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

Medicare Advantage plans, where PA requests increased from 37 million in 2021 to nearly 50 million in 2023.[28]

The commitment to process 80 percent of PA requests in "real time" by 2027 also raises concerns. The aggregate nature of the commitment could mask substantial delays for less common services. It lacks a clear definition of "real time" and creates incentives for speed over careful, individualized review. In practice, efforts to accelerate processing often rely on overworked clinicians or algorithmic tools that cut corners. A former Cigna medical director, for example, said that she and other doctors were pressured to rush through claim reviews without fully examining patient records.[29] Her superiors were "more concerned about being fast than being right." Without meaningful guardrails, transparency, or independent oversight, this pledge risks increased reliance on the very technologies that have undermined trust in PA.

VI. Conclusion

The 2024 Interoperability and Prior Authorization Final Rule represents a significant first step toward reforming PA across Medicaid and other covered payers. Many more steps remain. CMS has established long-overdue national baselines for timeliness, transparency, and electronic information exchange, but left substantial discretion to states and payers to decide how these requirements will function in practice. Key protections like meaningful, disaggregated public reporting, defined and protected appeals processes, active audits, and continuity of care protections are still needed. And critical services, like prescription drugs, have yet to be included in any kind of meaningful regulation.

Without a substantial federal enforcement framework, the Rule's impact will depend on how states choose to implement these changes. As states begin adopting new timeliness, notice, and public reporting measures in 2026 and rolling out electronic systems in 2027, advocates must keep a close watch on issues like clear notice rights, robust data transparency, and consistent oversight. True reform of PA requires more than new technology, loose commitments, and vague data reporting – it requires a genuine commitment to easing the burdens on beneficiaries and providers and facilitating outcomes that improve patient access to care.

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[28] Kaiser Family Foundation, *Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023*, KFF (Jan. 28, 2025), https://www.kff.org/medicare/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/.

[29] Patrick Rucker & David Armstrong, *Cigna Pressured Her to Review Patients' Cases Too Quickly, Says Former Cigna Medical Director*, ProPublica (Apr. 29, 2024), https://www.propublica.org/article/cigna-medical-director-doctor-patient-preapproval-denials-insurance.