mhpa Medicaid Health Plans of America

Through prior authorization, Medicaid Managed Care Organizations (MCOs) ensure vulnerable and underserved populations, many of whom experience chronic or complex medical conditions, have access to quality, affordable, and efficient health care.

Government Oversight of Prior Authorization and Medicaid MCOs

Managed care organizations are subject to multiple guardrails at the federal and state level.

Guardrails

- Open and transparent appeals and grievance processes help enrollees navigate any uncertainties with prior authorization issues.
- Government oversight affords both the state and enrollees with the flexibility to benefit from a competitive marketplace that provides numerous health plan options rather than limited selections
- To ensure medical necessity, Medicaid MCOs are permitted to place appropriate checks on certain services. Each state may have their own definition of "medically necessary services", based on state statute and regulation.
- When a provider indicates that following the standard timeframe for prior authorization could jeopardize the enrollee's life or health, Medicaid MCOs are required by federal regulations to make an expedited prior authorization decision within 72 hours.[1]
- Medicaid MCOs may not place prior authorization requirements on any Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services.[2]

The State's Role in Prior Authorization

In Medicaid, states implement additional regulations on prior authorization practices.

- Medicaid MCOs must follow prior authorization processes outlined in their contracts with State Medicaid agencies.
- State legislatures often introduce and pass legislation regulating prior authorization. In 2023, over half of states considered prior authorization bills.[3]

Streamlining Prior Authorization While Achieving Its Goals

- Medicaid MCOs are continuing to work to make the process easier and more streamlined for patients and providers.
- Medicaid MCOs are collaborating with the Centers for Medicare & Medicaid Services (CMS) and providers to improve transparency, reduce administrative burden, and implement more seamless, automatic processes for prior authorization.
  - Medicaid MCOs look forward to working with providers and CMS[4] to leverage the Fast Healthcare Interoperability Resources (FIHR) Application Programming Interface (API) to streamline and expedite prior authorization processes.
  - Allowing providers and Medicaid MCOs to share health information via a standardized system will improve the ability of health plans to approve services without burdening providers with requests for diagnosis data.

Sources:

- [1] 42 CFR § 438.210 - Coverage and authorization of services.
- [2] medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf
- [3] https://www.ama-assn.org/practice-management/prior-authorization/bills-30-states-show-momentum-fix-prior-authorization
- https://www.govinfo.gov/content/pkg/FR-2022-12-13/pdf/2022-26479.pdf