TOPIC: PRIOR AUTHORIZATION AND OTHER UTILIZATION MANAGEMENT APPROACHES

Background

Medicare pays Medicare Advantage (MA) plans a risk-adjusted, capitated payment for each month that a beneficiary is enrolled.[1] The MA organization agrees to authorize and pay for all medically necessary benefits covered by Traditional Medicare (TM).[2,3] MA organizations employ utilization management strategies to ensure that health care services are medically necessary and meet TM coverage requirements to help manage spending and to identify instances of fraud, waste, or abuse (FWA) by providers. MA organizations often require prior authorization for certain services, which means that a health care provider must get approval from the MA plan before delivering a covered service to an enrolled beneficiary.[4]

Key Points

- MA organizations use utilization management methods, such as prior authorization for certain services prior to delivery, to manage costs and identify instances of fraud, waste, or abuse by providers.
- The use of prior authorization or other utilization management strategies to delay care delivery and payment to providers inappropriately can be considered abusive; incentives may exist for MA organizations to deny or delay care to improve financial performance.
- Mitigation strategies include enhancing oversight, audits, and report information; creating federal standard guidance for utilization management strategies; banning all use of utilization management; continuing to ban the reopening of approved authorizations; and reducing delays due to prior authorization.

Potential for FWA

MA organizations' use of prior authorizations and claim denials and other utilization management strategies is likely effective at mitigating provider FWA, but these strategies can pose risks to beneficiaries. A 2022 report from the U.S. Department of Health and Human Services Office of Inspector General (OIG) found that, among requests denied by MA organizations, 13% of prior authorization requests and 18% of payment requests were for services that met Medicare coverage rules and MA billing rules.[5] Denying medically necessary care based on Medicare coverage determinations can be considered abusive.[6] Although some denial decisions are ultimately reversed, initial denials delay medically necessary care, result in some patients abandoning prescribed treatments or missing a window of beneficiary readiness for treatment, and can burden providers with administrative costs, creating waste by diverting resources away from clinical care. Prior authorization processes that delay care can also be abusive to the extent that the delays mean care is not delivered in

accordance with professionally recognized standards. In addition, there is a risk that prior authorization, claim denials, and delays may be applied inconsistently, which could disproportionately increase barriers to care among some subgroups of patients or providers.[7,8]

There is a potential incentive for MA organizations to inappropriately delay access to services and delay payment to improve financial performance.[9] MA organizations can invest the money they hold between the time they collect monthly capitation payments and beneficiary premiums and the timing of payment to providers, known as insurance float.[10] The MA organizations benefit from the returns on those investments, and, because the proceeds are excluded from the calculation of income in medical loss ratios, there may be an additional incentive for MA organizations to deny or delay payments to increase investment income.[11] The use of prior authorization or other utilization management strategies to delay care delivery and payment to providers inappropriately can be considered abusive.

Mitigation Approaches

Enhance oversight, audits, and report information to beneficiaries. Currently, CMS uses different mechanisms (i.e., program audits, enforcement actions, and Star Ratings) to oversee MA organizations' denial and appeal processes, identify inappropriate denials, and incentivize MA organizations to improve performance.[12] CMS also requires MA organizations to conduct oversight of utilization management. For example, as of January 2024, CMS required all MA organizations to establish a Utilization Management Committee to review and approve all prior authorization and other utilization management policies at least annually to ensure consistency with TM coverage decisions and guidelines.[13] In its 2027 final rule, CMS removed some requirements for MA organizations' utilization management committees;[14] it is unclear whether the changes will have any impact on fraud, waste, or abuse.

Utilization management strategies are not measured directly in Star Ratings but can indirectly appear in some measures. For example, if prior authorization denials lead to delays or gaps in care, patients may miss preventive services or medication adherence that is measured in the current quality indicators. In addition, if patients face many barriers to care due to utilization management policies, it could be reflected in Star Rating measures of disenrollment rates, member satisfaction, or complaints.[15] CMS has decided to remove the measures relating to appeals, complaints, and disenrollment from the Star Ratings calculations as of 2029.[16] The rationale included high performance on appeals and complaints measures, and that for the disenrollment measure, MA organizations expressed dissatisfaction with its calculation and claimed it is hard for beneficiaries to interpret.[17] There is some risk that removal of these Star Rating measures could reduce MA organizations' accountability for inappropriate denials; however, CMS does intend to continue monitoring or displaying some of these measures.[18]

One policy option is for CMS to require ***MA organizations to report more details about authorization denials*** like physician specialties, the service that was denied, the reasons for denials, and possibly the ownership interest between the provider and MA organization.[19,20,21] As of March 31, 2026, MA organizations must report publicly each year on their use of prior authorization, including the average time between the submission of a request and a determination; the percentage of requests approved, denied, and approved after appeals; and the items and services that require prior authorization.[22,23,24] Transparent reporting requirements can reduce the risks of abuse and can show whether provider ownership is associated with higher approval rates, suggesting possible waste. Another option is to report MA plans' denial rates and utilization management practices directly on Medicare Plan Finder, so it is easier for beneficiaries to access the information to compare plans.[25] An enforcement consideration for CMS is to direct MA organizations to examine their processes for manual review and system programming and correct vulnerabilities that result in inappropriate denials based on the data.[26] CMS could consider increasing oversight of MA plans with extremely high initial denial rates, overturn rates for denials, or low appeal rates.[27,28,29] CMS could use its civil monetary penalty authority to fine MA organizations for having too high a rate of prior authorization denials, reversals, or audit violations.

Another policy option is for CMS or MA organizations to ***publicly report prior authorization criteria***.[30] In the 2024 CMS final rule, CMS did not propose public reporting or provide comment on the topic but did encourage MA organizations to provide beneficiaries and providers with coverage or clinical criteria information relevant to individual prior authorization decisions.[31] Some states have started to require insurers to publicly post their prior authorization policies, clinical criteria, and documentation requirements for patients to access.[32] Making the criteria accessible to the public may increase transparency and deter fraudulent or abusive behavior like inconsistent use of prior authorization.

CMS could also ***include behavioral health services in audits of MA prior authorization*** usage.[33] A 2025 U.S. GAO report found that eight out of the nine MA organizations reviewed required prior authorization for behavioral health services and that CMS does not target these services in its oversight of prior authorization.[34] The prior authorization process and possible delays for behavioral health care services may result in missing a window of patient readiness for treatment, meaning patients may miss out on care consistent with professionally recognized standards.[35] In addition, behavioral health practices are particularly short staffed, so the prior authorization process may be more onerous and create more waste, for example, if it has to be done manually.[36] By scrutinizing use of prior authorization in behavioral health services, CMS can ensure that coverage criteria are consistent with TM and identify whether any MA organizations are not compliant with Medicare standards, thereby potentially identifying cases of abuse.[37] Similar to previous policy options, reporting prior authorization usage could deter

wasteful or abusive behaviors. MA organizations would need guidance on how to code and submit behavioral health service data to CMS, which may require more time and resources on the MA organization side.

Another policy option would be to ***include audit violation findings in the Star Rating measures*** with direct effect on quality ratings. As of 2019, CMS audit findings and enforcement activities of MA utilization management tools do not affect MA Star Ratings.[38] Instead, MA plans with audit violations have an indicator on Medicare Plan Finder that links to a list of violations.[39] Beneficiaries can use Star Ratings to evaluate and choose their health plans and plans' payments can be higher if they receive higher Star Ratings.[40] Including audit violations in MA plans' quality rating and subsequent payments would reduce the incentive for MA organizations to use utilization management inappropriately, promote transparency and accountability, and align financial rewards with quality metrics. Not all measures are appropriate for use in Star Ratings; if that were the case for an audit violation measure, other methods of public display could be considered.

For all oversight options mentioned, CMS would need more resources to monitor and audit MA plans in a more intensive and timely manner to deter improper behavior.

Create federal standard guidance for utilization management strategies. To mitigate fraud, waste, or abuse risks from improper use of utilization management tools, CMS or Congress could ***issue guidance about the appropriate use of AI***, including standards on human involvement in particular.[41,42] In the 2024 CMS final rule, CMS clarified the clinical criteria guidelines that MA organizations should use in medical necessity reviews.[43,44] These criteria are used by MA organizations to determine whether a specific health service should be approved or reimbursable.[45] Some MA organizations use AI or other algorithms to assist in these decisions. However, a 2022 OIG report found that most incorrect payment and prior authorization denials sampled were due to human error or system processing errors.[46] If AI models or algorithms are trained on historical data that include these errors, they risk perpetuating flawed decision-making. Currently, three ongoing court cases allege that MA organizations inappropriately relied on AI to make coverage decisions, disregarding clinical determinations by providers.[47,48,49] Some states have started to reinforce that human oversight is needed, require insurers to disclose the use of AI, and prohibit the use of AI systems to issue adverse determinations without human review.[50] A standard guideline can increase transparency and help CMS detect possible abuse propagated by AI.

Another policy option is for CMS to ***provide guidance to beneficiaries and providers about the appeals process and their appeal rights***.[51] Currently, less than 10% of adverse determinations are appealed.[52] This policy change may increase the volume of appeals initially but reduce the

volume over the long term because plans would have to weigh the costs of dealing with appeals versus the potential savings from denying care in borderline cases. CMS would need to consider how to disseminate this information to beneficiaries.

Ban all use of utilization management. An extreme policy option that has been proposed is to ban all use of prior authorization, utilization management strategies, and medical necessity reviews by MA organizations.[53,54] In response to public comments that called for a ban of all prior authorization use, CMS stated that it does not believe it has the authority to issue a sweeping prohibition of prior authorization and that the payment structure between the MA plan and provider for value-based care is a private matter.[55] To end the use of prior authorization, Congress could provide authority for independent physician-led nonprofit organizations to conduct prior authorization reviews.[56] This approach would remove the payers' profits from the decision-making process but would be costly to implement, based on experience with a similar Professional Standards Review Organization program that operated for around a decade starting in the 1970s.[57] Another approach to end prior authorization would be to reduce payments to providers modestly, recognizing that they would have greater professional autonomy and reduced administrative costs in the absence of prior authorization.[58] For any health care program, removing prior authorization would be difficult to implement, could increase premiums, and may reduce any cost savings that occur as a result of provider avoidance of the prior authorization process.[59] It is also unlikely to be feasible in MA given the range of different approaches to paying providers. The elimination of utilization management tools could reduce opportunities for vague-decision making that may hide fraud by MA organizations. However, banning all utilization management strategies would increase the risk of FWA by providers and remove a powerful tool that MA organizations can use to manage costs by reducing low-value or unnecessary care. In addition, MA organizations and providers would need clear, standard guidance on what items and services must be covered. Payment arrangements that move providers away from fee-for-service reimbursement and thereby reduce the incentive to deliver unnecessary services may be a more feasible approach to reducing the need for prior authorization in MA.[60]

Continue to ban the reopening of previously approved authorizations. By banning these reopenings, CMS reduced the ability of MA organizations to manipulate payment timing for financial gain by generating investment income and to shift the costs of previously approved care to providers and beneficiaries. CMS recently finalized a proposed rule that would restrict MA organizations' ability to reopen and possibly adjust a previously approved inpatient hospital admission authorization.[61,62] CMS stated that the goal of this provision is to ensure that MA organizations honor the approved prior authorization.[63] Previously, hospitals had to absorb the cost of inpatient admissions if MA organizations reversed previous decisions that deemed the admissions to be medically necessary and reimbursable.[64] Hospitals could also seek payments

from patients to cover the costs of the retrospective denial.[65] The introduction of this rule should help to reduce abuse risks associated with reversing decisions.

Reduce delays due to prior authorization. In June 2025, a group of health insurers with plans in MA and other markets pledged to implement six policies aimed at streamlining, simplifying, and reducing prior authorization.[66,67,68] Participating organizations promised to implement standardized prior authorization submission processes (already required for MA as of 2027),[69] reduce the scope of services for which prior authorization is required, honor existing prior authorizations for 90 days after a patient's change in insurance (already required for MA),[70] provide clear explanations of prior authorization decisions and guidance on appeals (required for MA starting January 1, 2026),[71] approve 80% of electronic prior authorizations in real time by 2027, and continue medical review of all denied requests.[72] These changes, if implemented consistently, could reduce delays in access to care and payments to providers and reduce waste related to providers' resources to handle prior authorization. The voluntary approach has some implementation benefits such as reducing lead time and cost of government spending on developing regulations. However, it also has risks, such as a lack of clarity regarding how CMS will measure and evaluate compliance, the possibility that the nonbinding pledge will fail to sustain changes long term, and the possibility that nonparticipating insurers may not change their behavior. The federal government has indicated that regulation remains a possibility if issuers do not comply with the pledge.[73]

Per the CMS 2024 final rule, and consistent with the pledge, starting in 2027, MA organizations are required to adopt and maintain Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) application programming interfaces (APIs) that aim to improve the exchange of information electronically and streamline the prior authorization process.[74] MA plans, patients, and providers will have access to patient data to increase transparency and reduce the burden of prior authorization and thereby reduce the waste of diverted clinical resources.[75] CMS could ***codify the adoption of a standard electronic prior authorization process*** to ensure long-term implementation and consistency for all involved.[76,77] By codifying the process, it becomes permanent and legally binding for the future. Permanent enforcement ensures long-term adherence and prevents MA organizations from reverting to less transparent practices that may conceal abuse.

Starting in 2026, CMS will require MA organizations to respond to standard prior authorization requests within 7 calendar days and urgent prior authorization requests within 72 hours.[78] CMS or states could implement policies to ***further reduce prior authorization timelines***.[79,80] For example, some states have prior authorization laws that cover MA and other payers and require responses to standard prior authorization requests within 3–5 working days.[81,82,83,84] One state's law requires a request to be automatically approved if an insurer misses the

deadline.[85] One organization suggests that the federal standard should be 72 hours for standard requests and 24 hours for urgent services.[86] With the adoption of an electronic prior authorization process in 2027, the process of sending and receiving needed documentation should be quicker and more efficient.[87] By reducing prior authorization timelines, there would be fewer delays in care, which would decrease the risk of abuse by MA organizations. [88,89]

Alternative policies could require MA organizations to automatically approve a service when the provider has a history of prior authorization approval of 90% or higher for that service, or ***"gold card" laws or policies***.[90,91,92,93] Gold card policies can be implemented at either the state or federal level or voluntarily by MA organizations.[94,95,96,97,98] They can streamline the prior authorization process for providers that usually get approved, reducing waste related to provider resources. With fewer delays and denials of necessary care, there is less risk of abuse by MA organization as their ability to increase investment income by delaying payment is lessened. In addition, this would allow MA organizations to focus on and investigate requests that may be more likely to involve provider FWA. Some implementation considerations include the timeline for notifying providers , how long providers need to be in good standing to receive gold-card status, and how providers could appeal if they lose gold-card status.[99,100,101,102] There are also considerations related to whether services should be included in the gold-card program or exempted from prior authorization altogether, such as in the case of low-cost, high-value services.

Regulate payment methods for prior authorization denials. Prior authorization vendors offer technology solutions to both payers and providers to support prior authorization processes. Although they may improve efficiency and timeliness, thereby reducing waste in processing requests and delays in decision-making, such technology can also create risks of fraud or abuse if they are calibrated to deny too many requests. A particular risk occurs if vendors are paid based on their volume of denials, as this creates an incentive to deny as many requests as possible, even if some requests should have been approved based on Medicare coverage criteria. One option to reduce this risk is to prohibit payment arrangements that involve vendors being paid based on their volume of denials. This option could reduce the volume of inappropriate denials.

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