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Texas Medicaid Managed Care: Prior Authorization

February 25,2019

What is Prior Authorization?

- Any process by which physicians and other health care providers must obtain advance approval from a health plan before a specific procedure, service, device, supply or medication is delivered to the patient to qualify for payment coverage.
- Texas MCOs are allowed to develop a utilization management program to include prior authorization to decrease costs and increase care effectiveness.

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MCO Prior Authorization

- Texas Medicaid MCOs may have different PA requirements than those in FFS Medicaid.
- MCOs must offer a sufficient benefit and ensure that services are furnished in an amount, duration, and scope that is equal to that furnished in FFS Medicaid.

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Amount, Duration, Scope

- Amount
  - Numerical quantity of a service available to a Medicaid Member.
  - MCOs must offer at least the same quantity of service or item to a Member as would be offered to that beneficiary under FFS Medicaid.

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Amount, Duration, Scope

- Duration
  - The length of time that a service is available to a Medicaid beneficiary.
  - MCOs must offer the Member the service or item for at least the same duration as would be offered to that same beneficiary under FFS Medicaid.

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Amount, Duration, Scope

- Scope
  - Scope encompasses the nature of a Medicaid benefit, what is included or excluded.
  - Which Members are eligible for the benefit?
  - Which Providers may provide the benefit?
  - Where may the benefit be provided?
  - What specific procedures are covered under the benefit category?

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Sufficient Services

- HHSC must, through contract, require MCOs to ensure that services are sufficient.
- MCOs are responsible for ensuring that all Medicaid services delivered remain sufficient in amount, duration, and scope.
- MCOs cannot arbitrarily deny or reduce the amount, duration, or scope of services to an otherwise eligible Member solely because of diagnosis, type of illness, or condition.

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Acute Care Utilization Review

- Unit formed in July of 2016 in response to SB 8 from the 83rd Texas Legislative Session, 2013.
- Provides oversight of Texas Medicaid MCOs to ensure MCOs use prior authorization and utilization management for the following:
  - Reduction of authorizations of unnecessary and inappropriate services.
  - Prevention of decreased access to care by denying necessary and appropriate service benefits.

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ACUR Oversight : Operational Reviews

- MCOs are reviewed once every two years as part of a cross-divisional operational review.
  - Utilization management policies and procedures reviewed for compliance with applicable HHSC managed care contracts.
  - Ensure appropriate implementation through:
    - Review of a sample of prior authorization documents.
    - Staff interviews and discussion with MCO leadership.

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ACUR Oversight : Operational Reviews

- Order is based on a risk assessment.
- Reviews include the following lines of business:
  - STAR
  - STAR Health
  - STAR+PLUS
  - STAR Kids

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ACUR Oversight : Operational Reviews

Pre-Onsight Review:

- Data analytics of prior authorization request data
- Desk Review:
  - MCO utilization management policies and procedures to determine compliance with applicable HHSC contracts and State and Federal regulations
  - Targeted sample review of prior authorization documents to ensure operationalization of MCO policy and procedures.

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ACUR Oversight : Operational Reviews

- Onsite review:
  - Walk-through of UM information systems
  - Prior authorization case reviews
  - Utilization management staff interviews
  - Discussion with MCO leadership to further ensure appropriate implementation of MCO policy and procedures.

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ACUR Oversight : Operational Reviews

- **Fiscal year 2018**
  - ACUR operational reviews focused on private duty nursing and speech therapy services.
- **Fiscal year 2019**
  - ACUR is expanding the scope of reviews to include additional service types such as:
    - durable medical equipment
    - behavioral health
    - occupational and physical therapy

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ACUR Oversight : Other Review Types

- Targeted Reviews
  - A review of a specific MCO may be expedited if HHSC identifies a potential risk through complaints, appeals, or other sources of information.
- Readiness Reviews
  - Utilization management system changes
  - Procurement and Re-procurement

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Timeliness Standards

- MCOs are operating under different requirements for processing prior authorization requests.
- Texas Department of Insurance (TDI) rules
  - MCO must issue an approval or denial for all PA requests, whether complete or incomplete, within three business days.
  - 2 days for an approval
  - 3 days for a denial
    - Allows 1 business day for an opportunity for peer-to-peer discussion to obtain needed information prior to an adverse determination.

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Timeliness Standards

- TDI standard reflected in the HHSC contracts with MCOs.
- HHSC's Uniform Managed Care Manual allows MCOs additional time to review incomplete PA requests when additional information is needed to authorize services for children.
  - UMCM requirements are more consistent with requirements imposed on HHSC’s administrative claims contractor for fee-for-service (FFS) Medicaid.
  - The additional time allowance is in conflict with TDI rules.

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Timeliness Standards

- HHSC is working to resolve the issues related to conflicting timeliness requirements.
- ACUR timeliness oversight
  - Review outcomes related to non-conflicting requirements.
  - Document these findings and require corrective actions.
- HHSC will provide guidance in an MCO Notice following resolution of this issue.

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Questions?

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