

UNIFORM MANAGED CARE MANUAL 15.6 Prior Authorization Annual Review Guidelines and Reporting Instructions

DOCUMENT HISTORY LOG

STATUS¹	DOCUMENT REVISION²	EFFECTIVE DATE	DESCRIPTION³
Baseline	2.0	January 31, 2022	Initial version Uniform Managed Care Manual Chapter 15.6, "Prior Authorization Annual Review Guidelines and Reporting Instructions." Chapter 15.6 applies to contracts issued as a result of HHSC RFP numbers 529-12-0002, 529-10-0020, 529-13-0042, 529-15-0001, 529-13-0071, and 529-12-0003.
Revision	2.0.1	September 15, 2020	Accessibility approved version.
Revision	2.1	September 1, 2024	Included rebuttal reference and annual description.

¹ Status should be represented as "Baseline" for initial issuances and "Revision" for changes to the Baseline version.

² Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "2.2" refers to the first version of the document and the second revision.

³ Brief description of the changes to the document made in the revision.



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Applicability of Chapter 15.6

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR Program, STAR Kids Program, STAR Health Program, STAR+PLUS Program, and Children's Medicaid Dental Services.

Purpose

Senate Bill (SB) 1207, 86th Legislature, Regular Session, 2019, amended Government Code Chapter 533, Subchapter A, by adding Section 533.00283 to require MCOs to develop and implement a process to conduct an annual review of the organization's prior authorization requirements, excluding prior authorizations for the vendor drug program. MCOs are required to solicit, receive, and consider input from providers in the organization's provider network and ensure that each prior authorization requirement is based on accurate, up-to-date, evidence based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted. The MCO may not impose a prior authorization requirement unless the organization has reviewed the requirement during the most recent annual review mandated under this section. The commission will periodically review each MCO to ensure compliance.

The Prior Authorization Annual Review Guidelines

Each MCO, in consultation with the organization's contractually required Provider Advisory Group (PAG) or other committees that include Network Providers, shall develop and implement a process to conduct an annual review of the organization's

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prior authorization requirements. The MCO is required to consult with the organization's PAG or other committees that include Network Providers prior to making changes to an existing annual review process.

In conducting a review, the MCO must comply with the following:

- 1) Review all existing and newly proposed procedure codes or services requiring prior authorizations no less than once annually;
 - a. The review may be divided into more than one review throughout the year.
 - b. "Annually" is defined as the date of most recent review occurring no more than 365 days (366 Leap Year) from date of previous review.
- 2) Report the results of all reviews, conducted throughout the review period, in one annual review deliverable;
 - a. The reporting period for the deliverable must align with the state fiscal year. For example: The state fiscal year 2020 report is due October 1, 2020. The dates covered in the report are September 1, 2019 through August 31, 2020.
 - b. The report is due October 1st following the reporting period;
 - c. If the due date falls on a weekend, state, or federal holiday on which HHSC's offices are closed, MCO's deadline will be the next business day.
 - d. The reviewed procedure codes or services must be reported at the procedure code level.
- 3) Solicit, receive, and consider input from Providers in the organization's Provider Network;
- 4) Ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted;
- 5) The MCO's website published version of the Prior Authorization Annual Review results must be updated, no later than 30 calendar days following the day of a review, to reflect the prior authorization decisions from each review;



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- 6) May not impose a prior authorization requirement unless the organization has reviewed the requirement during the most recent review, unless mandated by state or federal guidance to do so;
- 7) Maintain records of the annual review meeting minutes, agenda, and reports in accordance with HHSC records retention schedule; and
- 8) Report the Prior Authorization Annual Review results to HHSC using a standardized template provided in UMCM Chapter 5.27. The same standardized template must be used to publish the Prior Authorization Review results referenced in the UMCM Chapter 3.32 MMC/CHIP Website Critical Elements.

Prior Authorization Annual Review Report Submission Instructions

Each year, the MCO must submit a Prior Authorization Annual Review Report to the Health and Human Services Commission (HHSC) that includes information for each Medicaid managed care program (STAR, STAR Kids, STAR Health, STAR+PLUS, and Children's Medicaid Dental Services) for which the MCO provides services. The MCO must use the Prior Authorization Annual Review Report template provided in UMCM Chapter 5.27. HHSC may impose contractual remedies against any MCO that fails to comply with requirements in this chapter or fails to provide this deliverable in a timely and accurate manner or in the format specified by HHSC.

The MCO must submit report to the Contract Deliverables page in TexConnect using the naming convention of the MCO's choice.

HHSC will provide an email notification to the MCO with the draft findings report, and rebuttal template. If the MCO chooses to rebut findings in the report, they must do so by submitting the completed rebuttal template, according to the template instructions. Refer to the rebuttal process outlined in UMCM Chapter 15.7.

Submit additional questions to MCS_ManagedCareUR@hhsc.state.tx.us using the following naming convention in the email subject line: PA Annual Report_ACUR_MCO Name.



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