Quantitative Treatment Limitations (QTL, see separate tab for more information, derived from Section 5 of the CMS Parity Toolkit) and Nonquantitative Treatment Limitations (NQTL, see separate tab for more information, derived from Section 6 of the CMS Parity Toolkit) on Long Term Services and Supports (LTSS) provided directly by MassHealth

*Note: All LTSS Benefits are considered to be Medical/Surgical. Nursing Facilities, CDR Inpatient, and 24 hour Hospice are the only Inpatient Benefits. All other LTSS Services, including less than 24 hour Hospice are Outpatient.

Services	Medical Management Standards (question 2.a)	Network Admission Standards (question 2.c)	Other NQTLs (question 2.e)	QTLs (question 1)
Adult Day Health (ADH not available in CarePlus ABP)	Medical Appropriateness review	Reimbursement rates by fee schedule; licensure	None	Maximum 24 units per day (6 hrs)
Adult Foster Care (AFC not available in CarePlus ABP)	PA and Medical Appropriateness review	Reimbursement rates by fee schedule	Qualified setting requirements	14 day limit on alternative caregiver per member per calendar year
*CDR Inpatient	Preadmission screening, concurrent review, conversion review	Reimbursement rate by contract (per diem rate); accreditation; licensure	Facility requirements	CarePlus only limited to 100 days in combo with skilled nursing
CDR Outpatient	Yes (same as therapies limitation)	Reimbursement rate by contract (cost-to-charge ratio)	Facility requirements	None
Day Habilitation (DH not available in CarePlus)	Service Needs Assessment (to determine appropriate level of services)	Reimbursement rates by fee schedule	Facility requirements	Maximum 24 units per day (6 hrs), no more than 120 units per week (30 hrs)
Durable Medical Equipment (DME) - wigs , cochlear and ocular implants.	Prescription required; assessment and recommendation by a speech and language pathologist for cochlear implants; prior authorization.	Reimbursement rate by fee schedule; Medicare participation, accreditation	Facility requirements	None
Durable Medical Equipment – all other DME	Prescription and letter of medical necessity with a refill maximum of 12 months; PA for the majority of DME; PA for units in excess of limitations; PA for repairs over $1000.	Reimbursement rates by fee schedule; Medicare participation; accreditation (unless supplying only PERS or absorbent products);	Facility requirements	For members in a facility (acute, chronic, rehab, or psychiatric hospitals, ICFs, nursing facilities), MassHealth does not pay for medical supplies or absorbent products. Facilities are responsible for the first $500 towards the purchase of mobility systems for members who do not have a discharge plan. The following services are also not covered for members residing in a Nursing Facility: urological supplies, ostomy supplies, diabetic supplies, enteral/parenteral products or supplies. MassHealth does not pay for manual wheelchairs for members in nursing facilities, including transport chairs, standard manual wheelchairs, standard hemi wheelchairs, light weight wheelchairs, high-strength lightweight wheelchairs, ultra lightweight wheelchairs, heavy duty wheelchairs, amputee wheelchairs, and extra- heavy- duty wheelchairs.
Group Adult Foster Care	Medical Appropriateness review	Reimbursement rates by fee schedule	Qualified settings requirements	None
Home Health Agency	Prior authorization for services in excess of limitations (20 visits for PT or OT/35 for speech; 30 visits in a 90 day period for skilled nursing; 240 units in a 90 day period for home health aide services); PA for continuous skilled nursing services; medical appropriateness reviews.	Reimbursement rates by fee schedule; Medicare participation	None	CarePlus only: PA required for skilled nursing services limited to 14 days following discharge from an acute inpatient setting; limited to 100 days in combo with skilled nursing
*Hospice	Certification of terminal illness; election of services; medical appropriateness reviews;	Reimbursement rates by fee schedule; licensure; Medicare participation	None	None

Independent Nurse	PA (member must require continuous skilled nursing, which is a nursing visit of 2 or more hours)	Reimbursement rates by fee schedule; licensure	None	None
Independent Therapist	Prior authorization for services in excess of limitations (20 visits for PT or OT/35 for speech); medical appropriateness reviews	Reimbursement rates by fee schedule; licensure	None	None
*Nursing Facility	Medical appropriateness review (Clinical eligibility for nursing facility level of care) and federally-required PASSR review	Reimbursement rates by fee schedule; licensure	Medicare certification	None
Orthotics	PA for shoes in excess of limitations; prescription/physician's letter; medical appropriateness reviews.	Reimbursement rates by fee schedule; licensure; Medicare participation; Board certification; accreditation	Facility requirements; for orthotic providers, employ a certified orthotist; for prosthetics, employ a certified pedorthtist	None
Oxygen and Respiratory Therapy	PA for rental of certain equipment; medical appropriateness review	Reimbursement rates by fee schedule; Medicare participation; Controlled substances registration with DPH; accreditation	Employ at least one licensed respiratory technician; facility requirements.	None
Personal Care Attendant (PCA) (Not available in CarePlus)	PA; Medical appropriateness review	Reimbursement rates by fee schedule; newly hired PCAs must attend orientation and may not be a member's spouse, parent or foster parent (if consumer is a minor child); surrogate or legally responsible relative	PA for Overtime exceeding 50 hour/week limitation; Assessment of member's ability to manage and employ PCA, if Member determined unable to self-direct PCA services, a surrogate is required; Surrogate required in all instances for children and members with a court-appointed guardian	None
PCA: Transitional Living (Not available in CarePlus)	PA; Medical appropriateness review	Reimbursement rates by fee schedule; licensure or accreditation; PCAs may not be a member's spouse, parent or foster parent (if consumer is a child), surrogate or legally responsible relative	Qualified settings requirements	None

Prosthetics	Prescription; Prior authorization	Reimbursement rates by fee schedule; Medicare participation; board certification; accreditation	Facility requirements	Services not provided to hospitalized members, except for equipment prescribed for home use after discharge
Rehabilitation Centers	Prior authorization for services in excess of limitations (20 visits for PT or OT); PA for continuous skilled nursing services; medical appropriateness reviews	Reimbursement rates by fee schedule; licensure; accreditation	None	None
Speech and Hearing Centers	Prior authorization for services in excess of limitations (35 visits for speech therapy; continuous therapy for services discontinued by third-party payer); medical appropriateness reviews; prescription for audiological evaluation	Reimbursement rates by fee schedule; licensure; certification	None	None

NQTL

A non-quantitative treatment limitation (NQTL) is a limit on the scope or duration of benefits, such as prior authorization or network admission standards. Soft limits, or benefit limits that allow for an individual to exceed numerical limits for M/S or MH/SUD benefits on the basis of medical necessity, also are considered NQTLs.

• Medical management standards limiting or excluding benefits on the basis of medical necessity or medical appropriateness, or on the basis of whether the treatment is experimental
• Formulary design for prescription drugs
• Standards for provider admission to participate in a network, including reimbursement rates
• Refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective • Conditioning benefits on completion of a course of treatment
• Restrictions based on geographic location, facility type, or provider specialty
• Standards for providing access to out-of-network providers

Medical management standards
- Medical necessity criteria development
- Prior authorization
- Concurrent review
- Retrospective review
- Outlier management
- Experimental/investigational determinations
- Fail first requirements
- Exclusions (e.g., based on a failure to complete treatment)
- Medical appropriateness reviews
- Practice guideline selection/criteria
- Requirements for lower cost therapies to be tried first

Network admission standards
- Reimbursement rates
- Geographic restrictions
- Specialty requirements or exclusions
- Facility type requirements or additional requirements for certain facility types
- Network tiers

Out-of-network access standards
Methods for determining usual, customary, and reasonable charges
Formulary design for prescription drugs
Prescription drug benefit tiers
- Generic vs. brand name
- High cost vs. low cost

<u>Describe applicable processes, strategies, evidentiary standards, and other factors</u>

What criteria are applied to make a medical necessity/ appropriateness determination and how are they developed or selected? Describe the processes, strategies, evidentiary standards, and other factors applicable to developing/selecting your medical necessity and appropriateness criteria. What are the processes, strategies, evidentiary standards, and other factors applied in assigning medical necessity/ appropriateness reviews to benefits within each classification? What are the written and operating processes, strategies, evidentiary standards, and other factors applied during a medical necessity/ appropriateness review? Specifically address how frequency of review is determined and potential results following such a review

Quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits