Instructional Guide:

Texas Non-Quantitative Treatment Limitation Tool 3 - Medical Necessity

This document is the instructional guide for how to assess the non-quantitative treatment limitation (NQTL) of **medical necessity** in your benefits. **We are interested in how your plan has developed its medical necessity criteria and whether specific types of medical necessity criteria are applied**. This document accompanies the two Excel spreadsheets (Texas NQTL Assessment Tool Concurrent Review, and NQTL Classifications for Analysis JUNE FINAL) where the NQTL analyses will occur.

What are non-quantitative treatment limitations (NQTLs)?

NQTLs are limits on the scope or duration of benefits. The Centers for Medicare and Medicaid Services final rule issued March 2016 prohibits the application of non-quantitative limits (NQTLs) unless, under the policies and procedures of the state/MCO, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to BH benefits in the classification are comparable to, and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the NQTL to M/S benefits in the classification.

Medical Necessity

HHSC recognizes that all services must be medically necessary and that Medicaid plans must use the state's medical necessity guidelines defined in 1 T.A.C. §353.2 for Medicaid and 1 T.A.C. §370.4 for CHIP. The purpose of this NQTL Assessment is to assist your MCO is determining if your health plan's medical necessity **criteria development** meet federal parity requirements. This tool also assists your health plan in determining **whether any of the specific types of medical necessity criteria that your plan uses meet federal parity requirements**. Examples of criteria of interest to the Texas Health and Human Services Commission and to the Centers for Medicare and Medicaid services include, but are not limited, to the following criteria:

- Fail-first /low-cost alternatives first

- Level of engagement
- Degree of progress
- Probability of improvement

Though making medical necessity determinations are a part of the prior authorization and concurrent review processes, we are specifically interested in the **processes, strategies, evidentiary standards, and other factors** that your MCO uses to **develop medical necessity criteria** and your health plan's use of specific medical necessity criteria (listed).

Processes, Strategies, and Evidentiary Standard

Consider the policies, manuals, other documents, and practices that are related to the development of:

1) **medical necessity criteria overall, and**
2) **how the use of specific types of medical necessity criteria (listed below) impact the services and experiences of the individual beneficiary accessing these benefits.**
    - Fail-first /low-cost alternatives first
    - Level of engagement
    - Degree of progress
    - Probability of improvement

These are examples only, if your plan uses other types please assess your plan's use of these additional criteria.

Process:

Explain the process (in writing and in operation) that your plan uses to **develop** medical necessity criteria for MH/SUD and M/S benefits. Be as specific as possible. Include documentation or your policies/procedures with this spreadsheet.

Think about how your MCO **develops** medical necessity criteria and document it here. Also think about the criteria that were developed. Use the below set of questions as prompts to help you assess your plan's development of medical necessity criteria.

- How are the medical necessity criteria developed? Who are the people involved in developing the medical necessity development process? What are the qualifications or trainings of the individuals who are developing and reviewing procedures for applying medical necessity criteria?
- Do your medical necessity criteria include the use of, for example, fail-first policies/low-cost alternatives, level of engagement, progress requirements, and probability of improvement? How were these specific medical necessity criteria developed?
- If your MCO uses an evidence-based clinical decision-making tool (McKesson, Milliman, etc), what criteria did your MCO use to make the decision to use that specific tool?
- What modifications/alternations, if any, did you make to the evidence-based clinical decision-making tool to suit your MCO's particular needs? How was the decision made?
- How are medical necessity criteria for MH/SUD benefits reviewed and updated? M/S benefits?
- How is the frequency of medical necessity reviews for benefits determined? And what happens after the reviews?

Strategies: List, describe, and explain the **purpose and rationale** for applying the specific types of medical necessity criteria (fail first policies, amount of progress, low cost therapies first, probability of improvement) on the MH/SUD benefit and for the M/S benefits.

- If fail-first policies, probability of improvement, progress requirements, and/or use of low-cost therapies first are part of the medical necessity criteria, what is the purpose/goal/rationale for the application of these criteria to your benefits?
- Explain why the medical necessity criteria for MH/SUD and for M/S benefits are reviewed and updated with the frequency described.

Evidentiary Standards: Describe the evidentiary standard (association guidelines, internal data) used in making medical necessity criteria determinations.

- What evidentiary standards are used for the development of your plan's medical necessity criteria for MH/SUD and for M/S benefits?
- For the MH/SUD benefits, what evidentiary standards justifies the use of the following medical necessity criteria:
    - Fail-first /low-cost alternatives first
    - Level of engagement
    - Degree of progress
    - Probability of improvement
- For the M/S benefits, what evidentiary standards justify the use of the following medical necessity criteria:
    - Fail-first /low-cost alternatives first
    - Level of engagement
    - Degree of progress
    - Probability of improvement
- What evidence supports the frequency with which medical necessity criteria are reviewed and developed?

Comparability and Stringency

This step is to analyze the **comparability** and **stringency** of the application of the NQTL in BH benefits in comparison to M/S benefits that were described in Step 4.

Comparability Test: Is the application of medical necessity for MH/SUD benefits **comparable** to the application of medical necessity for M/S benefits?

- Does the development of medical necessity criteria include similar components, processes, and evidentiary standards for MH/SUD benefits as for M/S benefits in writing and in operation?
- If there are differences, are they arbitrarily applied? Are they consistent with practice guidelines?
- If there are differences in the entities/individuals developing the medical necessity criteria for MH/SUD versus M/S, are the differences comparable?
- Are there differences in the application of specific types of medical necessity criteria (fail first, amount of progress, low cost therapies first, level of engagement) between the MH/SUD benefits and M/S benefits?

Stringency Test Questions: Is the application of medical necessity to MH/SUD benefit **more stringent** than the application of medical necessity to M/S benefits?

- Is it harder to "pass" the medical necessity criteria (fail first, level of progress, low cost therapies first, level of engagement) in order to receive specific MH/SUD benefits than it is before receiving specific M/S benefits?
- What consequences/penalties apply when the specific medical necessity criteria listed are not met?
- Are the consequences to the member more severe for failing to meet the specific medical necessity criteria listed for MH/SUD benefits compared to M/S benefits?

If unsure whether your use of medical necessity on MH/SUD benefits violates parity, consider the following question:

Is there a disparate impact on MH/SUD benefits (e.g., higher denial rate) as compared to M/S benefits? While not determinative of parity noncompliance, disparate impact may

be a sign of non-comparable or more stringent processes and strategies, or evidentiary standards that require more analysis.