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## **Table of Contents**

**State/Territory Name:** Colorado

**State Plan Amendment (SPA) #:** CO-18-0027

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) State Plan Pages

**Children and Adults Health Programs Group**

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August 9, 2022

Tracy Johnson  
Medicaid Director  
Colorado Department of Health Care Policy and Financing  
Medicaid & Child Health Plan Plus (CHP+)  
1570 Grant Street  
Denver, CO 80203-1818

Dear Ms. Johnson:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), CO-18-0027 submitted on June 29, 2018, with additional information submitted on June 30, 2022, has been approved. Effective October 1, 2017, this SPA implements mental health parity requirements to ensure that financial requirements (FRs) and treatment limitations applied to mental health (MH) and substance use disorder (SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits.

Section 2103(c)(7)(A) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(d)(3)-(5), requires states that provide both M/S and MH/SUD benefits to ensure that FRs and treatment limitations applied to MH/SUD benefits covered under the state child health plan are consistent with the mental health parity requirements of section 2705(a) of the Public Health Service Act, in the same manner that such requirements apply to a group health plan. Colorado demonstrated compliance by providing the necessary assurances and supporting documentation that the state's application of FRs and non-quantitative treatment limitations to MH/SUD benefits are consistent with section 2103(c)(7)(A) of the Act.

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
Mail Stop: S2-01-16  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Telephone: (410) 786-3413  
E-mail: [Joyce.Jordan@cms.hhs.gov](mailto:Joyce.Jordan@cms.hhs.gov)

Page 2 – Ms. Tracy Johnson

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Amy  
Lutzky/

Amy Lutzky  
Deputy Director

SPA #27

**Date Amendment # 27 Submitted: June 29, 2018**

**Date Amendment # 27 Approved:**

**Date Amendment # 27 Effective: October 2, 2017 (Requested)**

Effective October 2, 2017, Colorado amended its State Plan to document its compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) under Sections 6.2 and 8.4

- 1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.**

**SPA number:** CO-18-0027

**Proposed effective date:** 10-02-2017

**Proposed implementation date:**

- 1.4-TC Tribal Consultation. (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.**

The State included consultation on this SPA in the tribal consultation log dated September 25, 2017. A copy of the relevant page of the consultation log is attached.

**6.2.2.2-DC**  State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)Page - 11 – State Health Official

**6.2.2.3-DC**  HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

- 6.2-DS**  **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

**Guidance:** Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. Previously 8.6

**6.2- MHPAEA** Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS’s contract review process at 42 CFR 457.1201(l).

**6.2.1- MHPAEA** Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

**6.2.1.1- MHPAEA** Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

International Classification of Disease (ICD)

Diagnostic and Statistical Manual of Mental Disorders (DSM)

State guidelines (Describe: \_\_\_\_\_)

Other (Describe: The State permits each Managed Care Entity (MCE) to use additional variables, such as the place of service, to assist in the classification of M/S and MH/SUD benefits, where appropriate. While these flexibilities are afforded to the MCEs, they do not replace the requirement to use the ICD and DSM criteria selected above.)

**6.2.1.2- MHPAEA** Does the State provide mental health and/or substance use disorder benefits?

Yes

No

**Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.**

**6.2.2- MHPAEA** Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

**6.2.2.1- MHPAEA** Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

Yes

No

**Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.**

**If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state’s provision of EPSDT.**

**6.2.2.2- MHPAEA** EPSDT benefits are provided to the following:

All children covered under the State child health plan.

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

**Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those**

**children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.**

**6.2.2.3- MHPAEA** To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

- All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))
  
- All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))
  
- All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))
  
- Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))
  
- Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))
  
- EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))
  
- The provision of all requested EPSDT screening services, as well as any corrective

treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

**Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.**

### **Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations**

**Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.**

**Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.**

The minimum essential benefit package is the same for all CHP+ members enrolled in the CHP+ MCEs.

**6.2.3-MHPAEA** In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

**6.2.3.1 MHPAEA** Please describe below the standard(s) used to place covered benefits into one of the four classifications.

The state classified services in the four categories based on the approach described in the CMS Parity Compliance Toolkit and guidance provide through the CMS/SAMHSA technical assistance process and the CMS parity academy. Recognizing that Federal parity regulations allow states some latitude in placement of benefits within each of these categories Colorado developed a preliminary definition list for use in classifying benefits in each category based on the current state plan benefit package. The state provided these definitions in a detailed parity compliance toolkit to MCOs to ensure that each plan properly assigned services within each category. After sending out the



state's parity compliance toolkit, the state held numerous technical assistance meetings with each MCO to assist in the assignment of services to each category and proper completion of the full compliance toolkit. This helped ensure consistency among MCOs when answering questions about each benefit category and provided the state a standardized toolkit for each MCO's demonstration of compliance.

The state used the following definitions for each category:

- **Outpatient:** Routine services that occur in an outpatient setting and are not included in the emergency category.
- **Inpatient:** Any non-emergency service that involves the individual staying overnight at a facility. This includes inpatient MH and SUD treatment and crisis stabilization services occurring in a facility.
- **Emergency:** Services or items delivered in an emergency department (ED) setting or emergency/crisis stabilization services, not requiring an overnight stay, which are not delivered in an inpatient setting.
- **Pharmacy:** Covered medications, drugs and associated supplies requiring a prescription.

**6.2.3.1.1 MHPAEA** The State assures that:

- The State has classified all benefits covered under the State plan into one of the four classifications.
- The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

**6.2.3.1.2- MHPAEA** Does the State use sub-classifications to distinguish between office visits and other outpatient services?

- Yes
- No

**6.2.3.1.2.1- MHPAEA** If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

- The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

**Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-**

**classifications to distinguish between outpatient office visits from other outpatient services.**

**6.2.3.2 MHPAEA** The State assures that:

Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

**Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).**

**Annual and Aggregate Lifetime Dollar Limits**

**6.2.4- MHPAEA** A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

**6.2.4.1- MHPAEA** Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

No dollar limit is applied

**Guidance: A monetary coverage limit that applies to all CHIP services provided under the State child health plan is not subject to parity requirements.**

**If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.**

CHIP+ Members are not subject to any aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits.

**6.2.4.2- MHPAEA** Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

Yes (Type(s) of limit:)

No

**Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on any mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on any mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))**

**6.2.4.3 – MHPAEA.** States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

**Guidance: Please include the state’s methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.**

**6.2.4.3.1-MHPAEA** Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

**6.2.4.3.2-MHPAEA** Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

**Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on any mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on any mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.**

**If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.**

**6.2.4.3.2.1- MHPAEA** If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

- The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

**Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.**

**6.2.4.3.2.2- MHPAEA** If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

- The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or
- The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

## Quantitative Treatment Limitations

**6.2.5- MHPAEA** Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

Yes (Specify: \_\_\_\_\_ )

No

**Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.**

CHP+ Members are not subject to any QTLs for mental health or substance use disorder benefits.

**6.2.5.1- MHPAEA** Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

**Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.**

**6.2.5.2- MHPAEA** Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR

457.496(d)(3)(i)(E))

**Guidance: Please include the state’s methodology and results as an attachment to the State child health plan.**

**6.2.5.3- MHPAEA** For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

**Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))**

**6.2.5.3.1- MHPAEA** For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

**Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))**

## Non-Quantitative Treatment Limitations

**6.2.6- MHPAEA** The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

**6.2.6.1 – MHPAEA** If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

**Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.**

CHP+ Members are not subject to any additional NQTLs applied to mental health or substance use disorder benefits.

**6.2.6.2 – MHPAEA** The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

**6.2.6.2.1- MHPAEA** Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

Yes

No

**Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.**

**6.2.6.2.2- MHPAEA** If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

- The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

**Availability of Plan Information**

**6.2.7- MHPAEA** The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

**6.2.7.1- MHPAEA** Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

- State
- Managed Care entities
- Both
- Other

**Guidance: If other is selected, please specify the entity.**

**6.2.7.2- MHPAEA** Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- State
- Managed Care entities
- Both
- Other

**Guidance: If other is selected, please specify the entity.**



**6.3** The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

**6.3.1.**  The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

**6.3.2.**  The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Describe: Previously 8.6

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

**6.4 Additional Purchase Options-** If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42

**8.4.3**  No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

**8.4.1-MHPAEA**  There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

**8.4.2-MHPAEA**  If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

**8.4.3-MHPAEA**  Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

**8.4.4-MHPAEA** Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify: Covered services for MH/SUD are listed within 6.2 through 6.2.28 and Co-Payments for all program benefits are listed in 8.2.3 through 8.2.4.

No

**Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.**

**Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.**

Pregnant women are not charged any co-pays for services received.

**8.4.5-MHPAEA** Does the State apply any type of financial requirements on any medical/surgical benefits?

Yes

No

**Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.**

**8.4.6- MHPAEA** Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

**Guidance: Please include the state’s methodology and results of the parity analysis as an attachment to the State child health plan.**

**8.4.7- MHPAEA** For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds (“substantially all”) of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

**Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))**

Each MCO completed the state’s MHPAEA Compliance Toolkit (Toolkit), submitting it to the state with supporting policies and an attestation of their compliance with the above regulation by an Officer of the organization. The state’s Toolkit was modeled from the CMS Parity Compliance Toolkit and contains a thorough analysis on the application of co-payments to M/S and MH/SUD benefits within each classification. All MCOs are required to complete numerous analyses within the Toolkit to analytically demonstrate their overall compliance, including compliance with the Two-Part Test. The analyses composed in the Toolkits allow the State to ensure state-wide compliance with 42 CFR 457.496.

**8.4.8- MHPAEA** For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to

medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

**Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))**

- 8.5 Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The 5% maximum allowable cost-sharing limit is calculated for each individual family. The annual amount is then recorded on the family's enrollment card with instructions in the member packet of the "shoe box" method and the process to be followed when the limit is reached.

State planners estimate that few families will reach their 5% limit. An analysis of the State's fee schedule suggests that cumulative cost sharing will rarely exceed 1% of the family's adjusted gross income. However, CHP+ administrative personnel make families aware of the aggregate limit on cost sharing through a number of information and educational sources.

Through direct communication with families, the CHP+ marketing and outreach efforts often discuss the aggregate limit on cost sharing. The first direct written communication with CHP+ families instructs parents that the expenditures on their child(ren)s health care through CHP+ should not exceed 5% of family income. Through contracts with Managed Care Organizations, the CHP+ administration ensure that the plans make their

enrollees aware of the aggregate limit on cost sharing by including information regarding the cost-sharing limit in their member handbooks.