Instructional Guide for Mental Health and Substance Use Disorder Parity State Summary Template

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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All acronyms are defined prior to their first use in this Instructional Guide

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Important Excel User Tips

Always use "Paste Values." Never use the standard paste when copy/pasting data. States may copy and paste information within the Template. However, when doing so, please do so using Paste Values option only.

How to copy/paste values or texts only.

Select the cell(s) and press Ctrl + c or choose "Copy" option to copy the data.

Select the destination, then choose one of the three ways below to paste values only.

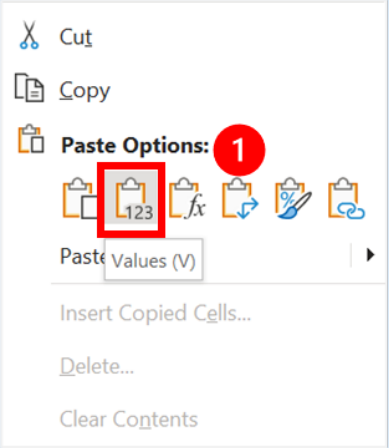
Option 1) Right click on the mouse to choose "Values" option.

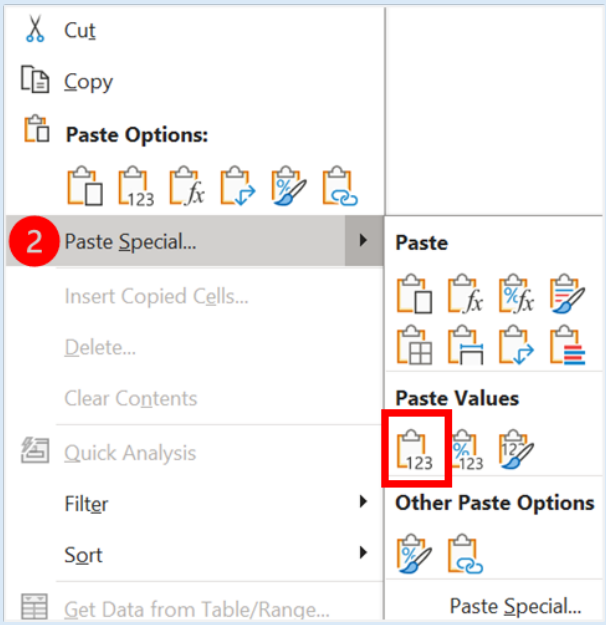
Option 2) Select 'Paste Values' from the 'Paste Special'

Option 3) Use keyboard shortcut Ctrl + Alt + v to paste values only.

Using standard paste (e.g., using Ctrl + v or using "Paste" option from the Excel's home ribbon) risks impacting the Template's functionality and may cause errors, particularly with the conditional formatting and drop-down menus.

See example below for how to use "Paste Values."





Do not drag and drop data into a cell. This worksheet uses multiple cell absolute and mixed cell references to populate information. Use the drop-down menus and copy/paste values when possible. This will prevent any #REF! error messages.

1 Background

The purpose of the Mental Health and Substance Use Disorder Parity State Summary Template (Template) and this Instructional Guide (Guide) is to support States, as well as the entities that provide benefits to enrollees in Medicaid managed care organizations (MCO), Alternative Benefit Plans (ABPs), or Children's Health Insurance Programs (CHIPs), in documenting compliance with mental health (MH) and substance use disorder (SUD) parity requirements to the Centers for Medicare & Medicaid Services (CMS).[1] The Template and this Guide, as well as the Mental Health and Substance Use Disorder Parity Managed Care Plan[2]/State Fee-for-Service (FFS) Program Reporting Template and its corresponding guide, are intended to standardize and improve States' documentation of parity compliance to CMS, streamline monitoring, and reduce administrative burden for States, managed care plans, and CMS.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related Medicaid, ABP, and CHIP regulations[3] apply MH and SUD parity protections to enrollees in Medicaid MCOs[4], Medicaid ABPs, and CHIPs. Within CMS, the Center for Medicaid and CHIP Services (CMCS) oversees and enforces parity protections for these populations through the Division of Managed Care Operations (DMCO), the Division of Benefits and Coverage (DBC), and the Division of State Coverage Programs (DSCP), respectively.

This Guide does not provide a primer on Federal parity requirements for Medicaid and CHIP. To assist States with implementing parity requirements, CMS hosted several webinars and issued a Parity Compliance Toolkit, a Parity Implementation Roadmap, and Frequently Asked Questions.[5] CMS also provides individualized technical assistance to States on an ongoing basis.

In 2023, CMS issued a Request for Comments (RFC) on processes for assessing parity compliance.[6] There was general consensus among RFC respondents including those representing States, managed care plans, and advocates, for CMS to provide standardized templates to improve the effectiveness of States' documentation of parity compliance to CMS, and the review of such documentation by CMS.

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[1] References to CMS in this Guide and the accompanying State Summary Template pertain to the Center for Medicaid and CHIP Services (CMCS) and relate to CMS' role in overseeing parity's application to Medicaid managed care, CHIP, and Medicaid ABPs. It does not refer to the Center for Consumer Information and Insurance Oversight (CCIIO) or any parity oversight that CCIIO performs.

[2] "Managed care plan" is used throughout the Guide and in the Reporting Template to refer to a Medicaid managed care organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP).

[3] The regulations implementing MHPAEA are found at 42 CFR § 438, subpart K for managed care, 42 CFR § 440.395 for ABPs, and 42 CFR § 457.496 for CHIP. Throughout this guide the term "parity" refers to these mental health (MH) and substance use disorder SUD) parity requirements, unless otherwise noted.

[4] In accordance with 42 CFR 438.3(n)(1), all MCO contracts, and any PIHP and PAHP contracts providing services to MCO enrollees must provide for services to be delivered in compliance with parity requirements insofar as those requirements are applicable.

[5] These aides, as well as other information pertaining to parity can be found at Parity | Medicaid.

[6] *Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP* (October 4, 2023), located at Request for Comments for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP (Medicaid.gov).

In 2024, CMS issued a CMCS Informational Bulletin (CIB)[7] that reiterated its expectations for States' documentation of parity compliance to CMS. This CIB also highlighted concerns raised by a report[8] from the U.S. Department of Health and Human Services Office of Inspector General (OIG) regarding a sample of State Medicaid MCO programs not complying with Federal parity requirements. The OIG found that five of the eight States sampled did not conduct parity analyses by a deadline set in Federal regulations. Also, none of the eight States made their documentation of compliance available to the public by the compliance date also set in Federal regulations. Per the OIG, these States may not have ensured that all services delivered to the MCO enrollees were parity compliant. The OIG recommended that CMS improve its oversight of States' parity compliance, and to support States ensure that managed care plans serving Medicaid enrollees are also parity compliant.

To address the RFC respondents' comments and the OIG findings, CMS developed the Template, this Guide, and the Mental Health and Substance Use Disorder Parity Plan/State FFS Reporting Template and its corresponding guide. In 2024, CMS also issued an RFC seeking comments on the templates and guides.[9] States and other stakeholders provided feedback, including suggestions for further streamlining the templates and clarifying requests for information within the templates. As a result, CMS updated the templates and guides.

As described above, these templates and guides are intended to support States in ensuring compliance with Federal parity requirements through improved documentation. Standardized documentation should streamline the monitoring of parity compliance and reduce administrative burden for States, managed care plans, and CMS. Importantly, these templates and guides support the overall objective that enrollees who need MH and/or SUD services can access such services at parity with access to medical and surgical (M/S) services.

1.1 Overview of Template

The Template includes multiple Excel worksheets (i.e., tabs) to collect introductory and overarching program type information (e.g., benefit classification mapping, definitions of MH/SUD and M/S) that support parity documentation as well as worksheets that correspond to the Federal parity requirements regarding:

[7] *CMCS Informational Bulletin: Medicaid and CHIP Managed Care Monitoring and Oversight Tools, including States' Responsibility to Comply with Medicaid Managed Care and Separate CHIP Mental Health and Substance Use Disorder Parity Requirements* (June 12, 2024), located at Managed Care Monitoring and Oversight Tools CIB 4_5.8.24 (medicaid.gov).

[8] HHS Office of Inspector General A-02-22-01016, *CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements* located at CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements, A-02-22-01016 (hhs.gov).

[9] *Templates for Documenting Compliance with Request for Comments on Mental Health Parity and Addiction Equity Act Requirements in Medicaid and CHIP*. (September 9, 2024), located at Request for Comments on Templates for Parity in Medicaid and CHIP.

- Aggregate lifetime dollar limits (ALs) and annual dollar limits (ADLs) (collectively referred to as AL-ADLs),
- Financial requirements (FRs),
- Quantitative treatment limitations (QTLs), and
- Nonquantitative treatment limitations (NQTLs)

The NQTL worksheets of the Template require States to document all NQTLs applied to MH and/or SUD benefits by entities that provide benefits within benefit packages[10] offered to enrollees in each program type (MCO, CHIP, ABP) in the State. States are required to analyze all NQTLs applied within these program types in the State for compliance with parity requirements. However, the Template highlights five NQTLs, listed below, for which there is additional documentation required in the Template.

1. Prior Authorization
2. Concurrent Review
3. Step Therapy/Fail First
4. Standards for Provider Network Admission *(only required for analyses that include one or more entity(ies) establishing a provider network, separate from the FFS network)*
5. Standards for Access to Out-of-Network Providers *(only required for analyses that include one or more entity(ies) establishing a provider network, separate from the FFS network)*

The Template includes multiple Excel worksheets that correspond with the Federal parity requirements, which are structured in separate worksheets for each program type: Medicaid MCO (in referred to as "MCO" in Template worksheets), Separate CHIP (referred to as "CHIP" in Template worksheets), and ABP. The State should enter information in these respective worksheets as follows:

- The State should use the MCO worksheets for all benefits delivered to MCO enrollees even if some benefits under the benefit package are delivered through FFS (i.e., they are "carved out" of managed care), including both non-ABP and ABP benefit packages, if delivered through an MCO.
- The State should use the CHIP worksheets for separate CHIP benefit packages, regardless of delivery system.
    - If the CHIP benefit package is a Medicaid expansion CHIP delivered through an MCO, the State should use the MCO worksheets.
    - If the CHIP benefit package is a combination CHIP benefit package, States should use the CHIP worksheets for the separate CHIP portion, and if the Medicaid

[10] A benefit package includes all services identified as MH/SUD and M/S benefits provided to a specific population group (e.g., children, adults, individuals with a nursing facility level of care) regardless of the authority, including long term care services. See Section 2.2, p. 9 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

expansion CHIP benefit package is delivered through an MCO, then States should use the MCO worksheets.

- The State should use the ABP worksheets for ABP benefit packages delivered entirely through FFS, or through a combination of FFS and Prepaid Inpatient Health Plan (PIHPs) and/or Prepaid Ambulatory Health Plan (PAHPs). However, the State should not use the ABP worksheets for ABP benefit packages delivered fully or partially through MCOs.

The State should complete the parity analysis at the benefit package level within each program type (Medicaid MCO, CHIP, and ABP).[11] The Template is structured to avoid duplication of data entry where possible (e.g., when an entity applies NQTLs identically across benefit packages and program types) to reduce administrative burden.

Due to the structuring of separate worksheets by program type (Medicaid MCO, CHIP, and ABP), not all worksheets will be relevant to every State. ***Non-applicable worksheet(s) should be left blank.*** The listing below provides an overview of each worksheet included in the Template; all worksheet titles are denoted with quotations. Acronyms in these titles are spelled out elsewhere in this Guide. The Instructions for Individual Worksheets section of this Guide will describe each worksheet's structure, purpose, and detailed instructions.

- Introductory Data Entry (8 worksheets)
  - "A_Instructions"
  - "B_Intro Data"
  - "C_MCO Program Type Data"
  - "D_CHIP Program Type Data"
  - "E_ABP Program Type Data"
  - "F_Methodology"
  - "G_Definitions MH-SUD MS"
  - "H_Benefit Classification Mapping"
- Medicaid MCO (7 worksheets)[12]
  - "I_All Limits-MCO"
  - "J_AL-ADL-MCO"
  - "K_FR-MCO"
  - "L_QTL-MCO"
  - "M_Intro NQTL-MCO"
  - "N_NQTL-MCO"
  - "O_Issues for Discussion-MCO"
- Separate CHIP (6 worksheets)[13]
  - "P_All Limits-CHIP"
  - "Q_FR-CHIP"

[11] Separate parity analyses are required for each benefit package within each program type (MCO, CHIP, ABP). For example, if an MCO program type included two benefit packages (one for parents and caretaker relatives, and one for aged, blind and disabled (ABD) individuals), the State should complete two parity analyses within the MCO program type worksheets.
[12] All MCO worksheets are color-coded in green.
[13] All CHIP worksheets are color-coded in orange.

  - "R_QTL-CHIP"
  - "S_Intro NQTL-CHIP"
  - "T_NQTL-CHIP"
  - "U_Issues for Discussion-CHIP"
- ABP (6 worksheets)[14]
  - "V_All Limits-ABP"
  - "W FR-ABP"
  - "X_QTL-ABP"
  - "Y_Intro NQTL-ABP"
  - "Z_NQTL-ABP"
  - "AA_Issues for Discussion-ABP"

Some worksheets include functionality that prevent users from reentering the same data. For example, the State must enter benefit package information in the "Program Type Data" worksheets; these entries then auto-populate the benefit package information in headers and drop-down menus in the "Benefit Classification Mapping," "AL-ADL," "FR," and "QTL" worksheets. The auto-populated fields will be locked so users cannot edit them.

The Template is designed to be flexible to reflect the unique composition of program types, benefit packages, delivery systems, and other differences specific to each State's Medicaid managed care, CHIP, and ABP program types. There are also free text fields within the Template to allow the State to add context that could not be conveyed through the structured data fields. If the State needs to provide additional information that could not be entered through the Template, the State should contact CMS as follows:

- Medicaid managed care: DMCO analyst.
- CHIP: CHIP Project Officer, DSCP.
- ABP: State Lead in the Division of Program Operations (DPO).

2 Instructions for Individual Worksheets

As described, the Template is organized by program type (Medicaid MCO, CHIP, and ABP). Except for nuances related to the application of AL-ADLs, the Template includes identical worksheets for each program type. However, this Guide is organized topically and includes a description of worksheets by topic (e.g., Program Type Data, FR, QTL, NQTL, Issues for Discussion). The State should follow these instructions when completing the applicable worksheet(s) regardless of program type.

2.1 Instructions

This worksheet ("A_Instructions") includes a linked table of contents for all worksheets in the Template and does not require State data entry.

[14] All ABP worksheets are color-coded in magenta.

2.2 Introduction Data

2.2.1 Overall Layout and Instructions

In this worksheet ("B_Intro Data"), the State should provide contact information for the main point(s) of contact for completing and submitting the Template. If more than one individual is responsible, the State should enter their information within the same field separating it clearly (e.g., with a semi-colon or comma). The State should also clarify the individual(s) CMS should contact for questions regarding specific programs (e.g., CHIP, ABP) using a parenthesis after their contact information. Required data elements are as follows:

- **State**: Select your State from the drop-down options.
- **Contact name**: Indicate the first and last name of the main point(s) of contact at the State for the parity submission.
- **Phone**: Indicate the phone number for the main point(s) of contact.
- **Contact email**: Indicate the email address for the main point(s) of contact.
- **Contact person's title**: Indicate the title of the main point(s) of contact.

The State should also provide information about the parity documentation, including:

- **What is the change requiring parity analysis?**
  - The State should describe the change that requires the State to submit or resubmit documentation to CMS to demonstrate how coverage complies with Federal parity requirements. If this is an initial submission due to a new program type (e.g., ABP) or entity (e.g., Medicaid MCO) being implemented, then the implementation of the program type or entity should be entered as the "change." Some circumstances that require a parity analysis and submission or resubmission of the Template include:
    - Medicaid MCO:
      - When a new MCO program is implemented.
      - When new managed care plans are added to an MCO program (i.e., new MCOs, PIHPs, or PAHPs) providing services to MCO enrollees).[15]
      - When benefits, services, FRs, QTLs, or NQTLs change.
      - When deficiencies are corrected.[16]
    - Separate CHIP:
      - When necessary, including when benefits, FRs, QTLs, or NQTLs change, when deficiencies are corrected, and when new managed

[15] See 42 CFR §438.3(n)(2).
[16] *CMCS Informational Bulletin: Medicaid and CHIP Managed Care Monitoring and Oversight Tools, including States' Responsibility to Comply with Medicaid Managed Care and Separate CHIP Mental Health and Substance Use Disorder Parity Requirements* (June 12, 2024), located at Managed Care Monitoring and Oversight Tools CIB 4_5.8.24 (medicaid.gov).

care plans are added to a managed care program (i.e., new MCOs, or PIHPs or PAHPs providing services to MCO enrollees).[17]
    - When there is a delivery system change.[18]
    - When there is a change in populations covered. For example, a Separate CHIP adds pregnant women as a covered population and provides a different benefit package than what is provided to children in the Separate CHIP.[19]
  - ABP:
    - When there is a new ABP State Plan Amendment (SPA) to implement delivered through FFS only.[20]
    - When there is an amendment to an approved ABP that is only delivered through FFS, and the amendment would change elements of the benefit package that are considered in a parity compliance determination, States must conduct a parity analysis to determine compliance with parity requirements. [21]
- **Effective date of change requiring parity analysis**:
  - This is the effective date of the change that requires the State to submit or resubmit the Template to CMS to demonstrate how coverage provided to enrollees of Medicaid MCOs and coverage provided by Medicaid ABPs and CHIPs complies with Federal parity requirements.
- **Is this an updated version of a prior submission or a new submission?**
  - The State should select "New submission" if the State has never submitted parity documentation to CMS or if the State has submitted parity documentation to CMS but not on this Template.
  - The State should select "Updated submission" if this is an updated version of a prior submission if the State has previously submitted parity documentation to CMS on this Template.
- **If this is an updated version of a prior submission of this Template, please provide a description of changes between this submission and the prior submission**:
  - The State should provide a brief description of the change(s) between this submission and a prior submission of this Template, including a listing of the worksheets that have been updated. For example, if a State corrected an outstanding issue in one program type in the updated submission and this affected

[17] *CHIP Parity SPA Guide* (January 2025), located at CHIP SPA Parity Guide.
[18] *CHIP Parity SPA Guide* (January 2025), located at CHIP SPA Parity Guide.
[19] *CHIP Parity SPA Guide* (January 2025), located at CHIP SPA Parity Guide.
[20] As noted previously, in situations where an ABP SPA is submitted for an ABP in which enrollees receive one or more benefits through a Medicaid MCO, the parity analysis would be conducted on the Medicaid MCO program type worksheets, and the analysis would be required based on the submission of the corresponding managed care contract submission.
[21] See Section 7, p. 55-56 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

one NQTL, the State would indicate that the change relates to this formerly identified "Issue for Discussion" in the NQTL worksheets.

- **Indicate number of workbook(s) the State is submitting.**
  - The State should enter a whole number to indicate the number of Excel workbooks – in other words, multiple Templates – it is submitting. If a State does not have sufficient space to enter the information requested in the Template, the State should submit an additional workbook(s).
  - For example, the State Summary Template has 15 spaces maximum for the number of entities that provide benefits in the State. If a State has more than 15 entities that provide benefits, it should submit an additional Template.

The remaining table in this worksheet, titled 'Consolidated State Program Type Overview,' should not be filled in by the State, as it represents consolidated data that is auto populated from entries in the following worksheets: "C_MCO Program Type Data," "D_CHIP Program Type Data," and "E_ABP Program Type Data." The State should complete the "C_MCO Program Type Data," "D_CHIP Program Type Data," and/or "E_ABP Program Type Data" worksheet(s), as appropriate.

2.3 Program Type Data (MCO, CHIP, ABP)

2.3.1 Overall Layout

The "C_MCO Program Type Data," "D_CHIP Program Type Data," and "E_ABP Program Type Data" worksheets all follow the same logic and have the same instructions, with only minor exceptions described below. The State should outline its benefit packages, delivery systems, and the entities that provide MH, SUD, and M/S benefits within those benefit packages.

The State should use the following worksheets according to the circumstances:

"C_MCO Program Type Data": for Medicaid MCO benefit package(s), including ABP benefit packages with one or more benefits delivered through a Medicaid MCO

"D_CHIP Program Type Data": for Separate CHIP benefit package(s).

"E_ABP Program Type Data": Only for ABP benefit package(s) delivered through FFS, or ABP benefit package(s) delivered through a combination of FFS and a PIHP and/or PAHP.

2.3.2 Instructions

Step 1: Program Type Overview

- Identify all benefit packages to which parity applies on separate rows.

A benefit package includes all services identified as MH/SUD and M/S benefits provided to a specific population group (e.g., children, adults, individuals with a nursing facility level of care) regardless of the authority, including long term care services.[22]

  - Identify ABP benefit packages delivered through FFS or through a combination of FFS and a PIHP and/or PAHP.
  - Identify separate CHIP benefit packages regardless of delivery system (i.e., managed care or FFS).
  - Identify all benefit packages when any Medicaid benefits are provided through Medicaid MCOs.
- For each benefit package row, identify the delivery system for each category of conditions (MH, SUD, and M/S) using the appropriate columns.
  - Choose the delivery system for MH, SUD, and M/S benefits from drop-down options:
    - All benefits delivered by single MCO;
    - FFS;
    - MCO with one or more benefits delivered in FFS and/or by PIHP, PAHP, and/or another MCO[23]; or
    - FFS with one or more benefits delivered by a PIHP and/or PAHP.
- Enter any notes or comments in the Notes/Comments Column (Column H).
  - If there are complexities around what types of MH, SUD, and M/S benefits are delivered using different delivery systems, the State may indicate those notes here. Using the Notes/Comments Column (Column H) to provide clarifying context may reduce review time.

An example of a completed Step 1 is shown in Figure 1.

Figure 1: Example Step 1 from Program Type Overview Worksheets

D. CHIP Program Type Data

Refer to Instructional Guide section 2.3 for more detail.

Step D-1: State CHIP Program Type Overview

Refer to Instructional Guide for detailed instructions.

Identify all benefit packages.	*Choose from delivery system drop-down options.*	*Choose from delivery system drop-down options.*	*Choose from delivery system drop-down options.*	*Enter any notes or comments.*
Benefit Package	**Delivery system for MH benefits**	**Delivery system for SUD benefits**	**Delivery system for M/S benefits**	**Notes/Comments**
Benefit Package 1	MCO with one or more benefits delivered in FFS and/or by PIHP, PAHP, and/or another MCO	MCO with one or more benefits delivered in FFS and/or by PIHP, PAHP, and/or another MCO	MCO with one or more benefits delivered in FFS and/or by PIHP, PAHP, and/or another MCO	Inpatient MH/SUD delivered FFS
Benefit Package 2	All benefits delivered by single MCO	All benefits delivered by single MCO	All benefits delivered by single MCO	
Benefit Package 3	MCO with one or more benefits delivered in FFS and/or by PIHP, PAHP, and/or another MCO	MCO with one or more benefits delivered in FFS and/or by PIHP, PAHP, and/or another MCO	MCO with one or more benefits delivered in FFS and/or by PIHP, PAHP, and/or another MCO	Intensive outpatient MH/SUD delivered FFS

Program Type Data Worksheets: How to reflect ABPs delivered through MCOs

Please note that the "C_MCO Program Type Data" and "E_ABP Program Type Data" worksheets include unique questions aimed at ensuring that all ABP benefit packages with one

[22] See Section 2.2, p. 9 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

[23] Note that even if one benefit (e.g., dental, vision) is carved out of a set of benefits delivered by an MCO, the State should use this option from the list of drop-down options.

or more benefits delivered through a Medicaid MCO have been appropriately identified and entered within the Template. These include the following fields:

In the "C_MCO Program Type Data" worksheet, Step C-1: State MCO Program Type Overview includes an additional column with the following question:

- Does this benefit package include ABP enrollees?
  - Choose "Yes" or "No" from the drop-down options for each benefit package.

In the "E_ABP Program Type Data" worksheet, Step E-1A asks the following question:

- Are there additional ABP benefit packages with benefits delivered through comprehensive managed care that are included in the MCO Program Type Data worksheet?
  - Choose "Yes" or "No" from the drop-down options.

All program type worksheets ("C_MCO Program Type Data," "D_CHIP Program Type Data," and "E_ABP Program Type Data") include the following for Step 2.

Step 2: Entities Providing Benefits

- The Benefit Package Column (Column D) in Step 2 includes a drop-down menu with selections that that are auto populated with the benefit packages that the State enters in Step 1.
- For each benefit package, identify all entities (i.e., the MCOs, PIHPs, PAHPs, or State FFS programs) that provide each type of benefit; that is, separately identify the entity that provides the MH benefit, the entity that provides the SUD benefit, and the entity that provides the M/S benefit.
  - If the State uses multiple entities to deliver benefits within a benefit package, the State should complete multiple rows for that benefit package.
    - For example, if the State contracts with four MCOs to offer all benefits in Benefit Package X, then select Benefit Package X in four separate rows, and then indicate the relevant entities.
  - If both a managed care entity and a State FFS program provide services within one type of benefit (e.g., MH), use a separate row per delivery system to indicate which entities provide services within that type of benefit (e.g., MH).
    - Example: If preventative MH services are delivered through managed care, and acute MH services are delivered through FFS, use two rows to indicate the entities that provide the services for MH benefit in the benefit package. An example of how these entities should be entered in Step 2 is shown in Figure 2. Notes/Comments in column H should summarize which benefits in that category are provided through which delivery system.

Figure 2: Example Step 2 from Program Type Overview Worksheets with Benefits Delivered through Multiple Entities

A B C	D	E	F	G	H	I
Step C-2: MCO Program Type Benefit Packages - Entities Providing Benefits						
Refer to Instructional Guide for detailed instructions.						
Auto-populated	*Choose from dropdown*	*Identify the specific entity that provides MH benefits.*	*Identify the specific entity that provides SUD benefits.*	*Identify the specific entity that provides M/S benefits.*	*Enter any notes or comments.*	*Auto-calculated field. If MH and SUD entity names are **identical**, then this field will indicate Y. If the result is not expected, check spelling and spacing.*
MCO ID	**Benefit Package**	**Entity Providing Benefits - MH**	**Entity Providing Benefits - SUD**	**Entity Providing Benefits - M/S**	**Notes/Comments**	**CACLULATED FIELD. Y: If MH & SUD are provided by the same entity N: MH & SUD are provided by different entities**
1-MCO	Benefit Package 1-MCO	MCO A	MCO A	MCO A	Preventative MH services delivered by MCO	Y
2-MCO	Benefit Package 1-MCO	State FFS	State FFS	MCO A	Acute MH services delivered through FFS	Y

- Notes/Comments Column (Column H).
  - States should use Column H to clarify complexities regarding the way benefits are delivered in the benefit package. When multiple entities provide services for a type or types of benefits within a benefit package (such as in Figure 3), the Notes/Comments should summarize how services within the type of benefit(s) are provided by which entity. In the example, two different entities (MCO A and State FFS) with two different delivery systems (managed care and FFS, respectively) provide services within the MH and SUD benefits. Those MH and SUD services identified as preventive services are provided by the MCO, while those identified as acute services are provided by the State. Furthermore, if a listed entity (e.g., an MCO) utilizes a vendor or subcontractor to deliver certain services, that arrangement should be described in the Notes/Comments Column.
- The Calculated Field Column (Column I) in Step 2 of this worksheet is an auto-calculated column and no action is needed by the State in this column. The calculation indicates if services provided as MH benefits and SUD benefits are provided by the same entity or not. This logic feeds into the "Intro NQTL" worksheets to ensure that, if separate entities provide MH and SUD benefits, there are separate analyses requiring the correct comparison between MH and M/S, and between SUD and M/S benefits.
  - When services provided as MH benefits and SUD benefits are provided by the same entity, Column I will show "Y."

Please note, the names of the Entity Providing Benefits (in columns E, F, and G) need to be entered exactly the same (e.g., no extra spaces, same capitalization) for the logic in the Calculated Field Column to work.

If the same entity is entered inconsistently, an "N" will appear in the row in the Calculated Field Column (Column I), and the cell will be shaded yellow (see example in Figure 3). In these instances, the State should double-check to ensure the entities providing MH and SUD are, in fact, different.

Figure 3: Example Step 2 "Calculated Field" Functionality from Program Type Overview Worksheets

Step C-2: MCO Program Type Benefit Packages - Entities Providing Benefits

Refer to Instructional Guide for detailed instructions.

MCO ID	Benefit Package	Entity Providing Benefits - MH	Entity Providing Benefits - SUD	Entity Providing Benefits - M/S	Notes/Comments	CACLULATED FIELD Y: If MH & SUD are provided by the same entity N: MH & SUD are provided by different entities
Auto-populated	*Choose from dropdown*	*Identify the specific entity that provides MH benefits.*	*Identify the specific entity that provides SUD benefits.*	*Identify the specific entity that provides M/S benefits.*	*Enter any notes or comments.*	*Auto-calculated field. If MH and SUD entity names are **identical**, then this field will indicate Y. If the result is not expected, check spelling and spacing.*
1-MCO	Benefit Package 1-MCO	MCO A	MCO A	MCO A	Preventative MH services delivered by MCO	Y
2-MCO	Benefit Package 1-MCO	State FFS	State FFS	MCO A	Acute MH services delivered through FFS	Y
3-MCO	Benefit Package 2-MCO	MCO A	MCO A	MCO A		Y
4-MCO	Benefit Package 2-MCO	MCO B	MCO**B**	MCO B		**N**
5-MCO	Benefit Package 3-MCO	MCO A	MCO A	MCO A		Y
6-MCO	Benefit Package 3-MCO	MCO B	MCO B	MCO B		Y

2.4 Methodology

The State should complete the "F_Methodology" worksheet regardless of applicable program type(s). In this worksheet, the State should explain the process used to conduct the parity analysis the State is reporting in the Template.

This worksheet includes six fields:

- ID# F-1**:** The State should list all information sources reviewed and analyzed to populate the Template, as well as the applicable time period for the information analyzed.

  For example, if a State reviewed a managed care plan's utilization management policies, it should list the name of the policy documentation reviewed, and either the date the documentation was most recently updated, or the contract period for which the utilization management policies were in effect.

  CMS may request copies of the information and/or data listed in this worksheet, if necessary to resolve questions during CMS' review of the Template.

- ID# F-2**:** The State should explain how it gathered the information reviewed.

  This could include a description of the Plan/State FFS Reporting Template provided by CMS, surveys, and/or questionnaires provided to managed care plans or completed by the State agency; descriptions of parity templates the State distributed for completion; and/or an explanation of source documentation the State required to perform its analysis.

- ID# F-3**:** The State should briefly describe the benefit packages that it offers and that are analyzed within the Template.

  This question requests a brief narrative overview of the benefit packages and delivery systems the State uses. While separate worksheets will capture detailed information, this field should be used to summarize the landscape of benefit packages per program, delivery systems, and entities that provide benefits that would provide helpful context for the analysis. For example, the structure and extent of any types of benefits that are not included in an MCO's contract and are provided using another delivery system or through

a different managed care plan should be described in this field. Conversely, if all benefits are delivered through comprehensive managed care, that should also be indicated here.

- ID# F-4**:** The State should identify whether there were issues or challenges that affected the accuracy of information reported in the Template.

  If the answer is yes, the State should provide a description of the issues and challenges and what step(s)/strategy(ies) it took to resolve or mitigate them. If the answer is no, no further information is necessary.

- ID# F-5: The State should describe its ongoing parity compliance monitoring plan.

  The Template provides a point-in-time assessment of parity compliance. In response to this question, the State should describe the approach, process, and/or steps it will execute to ensure ongoing parity compliance.

- ID#F-6: The State should describe all policies, procedures, contract requirements, and/or limitations relevant to parity that it requires of the entities that provide MH, SUD, and/or M/S benefits in the State. The State should describe how these policies, procedures, contract requirements, and/or limitations are compliant with Federal parity requirements throughout the template.

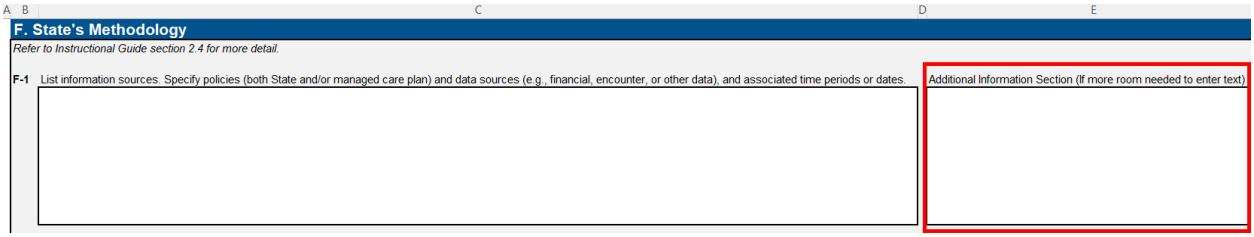
  The State should describe policies, procedures, contract requirements, and/or limitations that are imposed by entities providing benefits *because of* a State requirement.

- ID#F-7: The State has the option to provide additional information regarding its parity analysis.

  This question is optional and provides additional free text space for the State to provide any additional information that could not be conveyed through the Template, but that the State believes is important to their parity analysis. The State should not use this space to provide information otherwise requested in the Template.

Note that each cell for responses has a 32,767-character limit. If additional space is needed, States should use the "Additional Information Section" field in Column E (See Figure 4).

Figure 4: Additional Information Section in Methodology Worksheet



2.5 Definitions of MH-SUD and MS

2.5.1 Overall Layout and Instructions

This worksheet ("G_Definitions MH-SUD MS") requires the State to describe how it defines MH, SUD, and M/S conditions.[24] the four benefit classifications: inpatient, outpatient, emergency care, and prescription drugs.[25] The questions and responses in this "G-Definitions MH-SUD MS" worksheet apply to all benefit packages listed in the "B_Intro Data" worksheet. Each question is associated with an ID in the ID# Column (Column A) (see Figure 5 below).

- IDs# G-1-2: The State should enter its M/S definition. The drop-down options for ID# G-1 are: International Classification of Diseases (ICD); or Other. The State should only select "ICD" if its guidelines are 100% aligned with those in the ICD. Otherwise, it should select "Other" in ID# G-1 and explain in ID# G-2 how its guidelines deviate from the ICD.
- IDs# G-3-4: The State should enter its MH definition. The drop-down options for ID# G-3 are: ICD; Diagnostic and Statistical Manual of Mental Disorders (DSM); or Other. The State should only select "ICD" or "DSM" if its guidelines are 100% aligned with those in the ICD or DSM, respectively. Otherwise, it should select "Other" in ID# G-3 and explain in ID# G-4 how its guidelines deviate from the ICD or DSM as applicable.
- IDs# G-5-6: The State should enter its SUD definition. The drop-down options for ID# G-5 are the same as those listed for ID# G-3 above. The State should only select "ICD" or "DSM" if the guidelines are 100% aligned with those in the ICD or DSM, respectively. Otherwise, it should select "Other" in ID# G-5 and explain in ID# G-6 how its guidelines deviate from the ICD or DSM as applicable.
- IDs# G-7-10: The State should enter its definitions of the inpatient, outpatient, emergency care, and prescription drug classifications. IDs# G-7-10 are free-text cells with no drop-down response options.

[24] See Section 3, p. 10-15 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

[25] See Section 4, p. 16-20 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

Figure 5: Example Definitions MH-SUD MS Worksheet

A	B	C	D
G. State's Definitions of M/S, MH, and SUD			
Refer to Instructional Guide section 2.5 for more detail.			
ID#	**Question**	**Response Type**	**Response**
G-1	Which generally recognized independent standard of current medical practice does the State use to define M/S conditions?	Dropdown	International Classification of Diseases (ICD)
G-2	If the State selected "other," explain how the standard deviates from ICD.	Free-text	
G-3	Which generally recognized independent standard of current medical practice does the State use to define MH conditions?	Dropdown	Diagnostic and Statistical Manual of Mental Disorders (DSM)
G-4	If the State selected "other," explain how the standard deviates from ICD or DSM as applicable.	Free-text	
G-5	Which generally recognized independent standard of current medical practice does the State use to define SUD conditions?	Dropdown	International Classification of Diseases (ICD)
G-6	If the State selected "other," explain how the standard deviates from ICD or DSM as applicable.	Free-text	
G-7	How does the State define the inpatient classification?	Free-text	
G-8	How does the State define the outpatient classification?	Free-text	
G-9	How does the State define the emergency care classification?	Free-text	
G-10	How does the Stare define the prescription drug classification?	Free-text	

2.6 Benefit Classification Mapping

2.6.1 Overall Layout and Instructions

Each column listed in this worksheet ("H_Benefit Classification Mapping") is discussed in detail below.

- Column A has free-text cells where the State should identify each service within the benefit packages included in the Template.
- Column B includes two drop-down options (M/S or MH/SUD). For each service listed, the State should indicate if the service is a M/S or MH/SUD benefit.
    - If the same service is used to treat a MH/SUD condition and a M/S condition, the state should use two rows (i.e., one for each service) to indicate that the service is used for both a MH/SUD and a M/S condition.
- Column C includes four drop-down options (Inpatient, Outpatient, Emergency Care, Prescription Drugs). For each service listed, the State should indicate the benefit classification.
- Column D only applies to services that are included in ABPs and requires the State to indicate if the service listed in Column A is an essential health benefit (EHB) or an "Other 1937" service. The drop-down options for Column D include: "EHB"; "Other 1937"; or NA.

If any ABP benefit packages appear in Columns E-AR, the State should select "Yes" or "No" in Column D. If none of the benefit packages in columns E-AR are an ABP, the State will select "NA" in Column D.

The header cells in Columns E-AR will be auto-populated based on the benefit package information that the State entered in the 'C_MCO Program Type Data,' 'D_CHIP Program Type Data,' and 'E_ABP Program Type Data' worksheets.

- Columns E-AR require the State to indicate to which benefit packages the services in Column A – and the associated responses in Columns B-D – apply. The State should

select "Yes" or "No" in the corresponding benefit package columns (Columns E-AR) to indicate if the service in Column A is covered in the applicable benefit package.

Figure 7 provides an example of how a State would list the Acupuncture service and Ambulatory Detoxification service, assuming the former is a M/S benefit and the latter a MH/SUD benefit in the outpatient benefit classification. This example includes two benefit packages, one of which is an ABP. Because an ABP is included in the example, Column D must be completed.

Figure 6: Example Benefit Classification Mapping Worksheet with EHB Indication

A	B	C	D	E	F
H. Benefit Classification Mapping					
Refer to Instructional Guide section 2.6 for more detail.					
Identify the service.	*Indicate if the service is a MH/SUD or M/S benefit.*	*Select the benefit classification from the drop-down options.*		*Is the service in Column A covered in the benefit package below? Choose from dropdown (Yes/No)*	*Is the service in Column A covered in the benefit package below? Choose from dropdown (Yes/No)*
Service	**MH/SUD or M/S**	**Benefit Classification(s)**	**For services included in an ABP, indicate if the service is an Essential Health Benefit (EHB) or Other 1937 service. If there are no ABPs, indicate NA.**	**Benefit Package 1-MCO**	**Benefit Package 1-ABP**
Acupuncture	M/S	Outpatient	Other 1937	Yes	Yes
Ambulatory Detoxification	MH/SUD	Outpatient	EHB	Yes	Yes

2.7 All Limits (Medicaid MCO, CHIP, ABP)

2.7.1 Overall Layout and Instructions

The All Limits worksheets ("I_All Limits-MCO," "P_All-Limits-CHIP," and "V_All Limits-ABP") include questions regarding the application of AL-ADLs, FRs, and treatment limitations to MH/SUD benefits that will guide the State to complete, as necessary based on the program type, the subsequent AL-ADL, FR, QTL, and/or NQTL worksheets. The State should complete each of the All Limits worksheets, as applicable to the State's overall Medicaid managed care, CHIP, and ABP program types.

Note that the instructions for each of the All Limits worksheets are the same, as described below, except for the "I_All Limits-MCO" worksheet, which includes two additional questions regarding ALs or ADLs.[26] The questions within each All Limits worksheet only pertain to the benefit packages in that program type. For example, all questions included in the "P_All Limits-CHIP" worksheet only pertain to the CHIP benefit package(s). However, each question is asking whether an AL or ADL, FR, QTL, or NQTL, respectively, is applied to MH/SUD benefits for any benefit classification within any benefit package offered within that program type. For example, if a State offers two Medicaid MCO benefit packages, and only includes QTLs that apply to MH/SUD benefits in one of them, the State should still answer "yes" when asked whether it applies QTLs.

[26] The "All Limits-CHIP" worksheet does not include questions related to ALs or ADLs because new ALs or ADLs on medical or dental services which are covered under the State plan are currently prohibited in separate CHIPs, and existing ones must be phased out by mid-2025. See 42 CFR § 457.480; see also Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, Fed. Reg. 22,834, 22,836 (Apr. 2, 2024).

- In IDs# 1-2 of the "I_All Limits-MCO"[27] worksheets, the State should answer: "Yes" or "No" to applying ALs or ADLs in any benefit package.
  - "I_All Limits-MCO"
    - If the State answers "Yes" to including ALs or ADLs for MH/SUD benefits, the State should complete the "J_AL-ADL-MCO" worksheet.

The remaining questions in the All Limits worksheets are the same for each program type (ID#s I-3-9 in the "I_All Limits-MCO" worksheet, ID#s P-1-7 in the "P_All Limits-CHIP" worksheet, and ID#s V-1-7 in the "V_All Limits-ABP" worksheet) and relate to the application of FRs (e.g., copayments, coinsurance, deductibles), QTLs (e.g., hour limits, day limits, waiting periods), and NQTLs (e.g., prior authorization, fail first/step therapy) to MH/SUD benefits in any benefit package and in any benefit classification.

If a State applies FRs to MH/SUD benefits in any benefit package, for the inpatient, outpatient, and/or emergency care benefit classifications, it should complete, as necessary based on the program type, the "K_FR-MCO," "Q_FR-CHIP," and "W_FR-ABP" worksheets.

If a State applies FRs to MH/SUD benefits in the prescription drug benefit classification and answers "no" to ID#s I-5-6 (MCO), P-3-4 (CHIP), and/or V-3-4 (ABP), it should complete, as necessary based on the program type, the "K_FR-MCO," "Q_FR-CHIP," and "W_FR-ABP" worksheets for the prescription drug benefit classification as well.

There are separate instructions related to the special rule for multi-tiered prescription drugs.[28] If within one or more program types (Medicaid MCO, CHIP, or ABP) a State applies different levels of FRs to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed for M/S benefits or for MH or SUD benefits, then information on the FRs being applied to prescription drugs do not need to be entered in the "K_FR-MCO," "Q_FR-CHIP," and "W_FR-ABP" worksheets. Instead, the State should describe what the reasonable factor is (i.e., cost, efficacy, generic versus brand name, and/or mail order versus pharmacy pick-up/delivery) in ID# I-7 (I_All Limits-MCO), ID# P-5 (P_All Limits-CHIP), and ID# V-5 (V_All Limits-ABP). If the State cannot attest to applying different levels of FRs to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed for M/S benefits or for MH or SUD benefits, the State should complete the "K_FR-MCO," "Q_FR-CHIP," and/or "W_FR-ABP" worksheets, as necessary based on the program type, and the State should describe the issue in the corresponding Issue for Discussion worksheets ("O_Issues for Discussion-MCO," "U_Issues for Discussion-CHIP", or "AA_Issues for Discussion-ABP"). See Figure 8 for an example of how the special rule is incorporated into the worksheets.

[27] See 42 CFR § 440.395(e)(1). For states "providing ABPs through an MCO, PIHP, or PAHP, the rules of 42 CFR part 438, subpart K also apply." As such, states providing ABPs through an MCO, PIHP, or PAHP that use ALs or ADLs must also comply with the AL or ADL requirements set forth in 42 CFR § 438.905.

[28] 42 CFR § 438.910(c)(2)(i), 42 CFR § 457.496(d)(3)(ii)(A), 42 CFR § 440.395(b)(3)(ii)(A) for MCO, CHIP, and ABP, respectively.

Figure 7: Example All Limits Worksheet showing "Special Rule"

A	B	C	D	E
I. Financial Requirements and Treatment Limitations - MCO				
Refer to Instructional Guide section 2.7 for more detail.				
General Section - Aggregate Lifetime and Annual Dollar Limits, Financial Requirements, Quantitative Treatment Limits, and Nonquantitative Treatment Limit				
Question ID	**Question**	**Response Type**	**Response**	**Instruction**
I-1	Does the State apply aggregate lifetime dollar limit(s) (AL) to MH/SUD benefits in any benefit package?	Dropdown	Yes	If Yes, complete the AL-ADL-MCO worksheet.
I-2	Does the State apply annual dollar limit(s) (ADL) to MH/SUD benefits in any benefit package?	Dropdown	Yes	If Yes, complete the AL-ADL-MCO worksheet.
I-3	For the inpatient, outpatient, or emergency care benefit classifications, does the State apply any financial requirement(s) (FR) to any MH/SUD benefits in any benefit package?	Dropdown	Yes	If Yes, complete the FR-MCO worksheet.
I-4	For the prescription drug benefit classification, does the State apply FRs to any MH/SUD benefits in any benefit package?	Dropdown	Yes	If Yes, respond to #I-5.
I-5	If Yes to #I-4, does the State apply different levels of FRs to different tiers of prescription drug benefits in any benefit package?	Dropdown	Yes	If No, complete the FR-MCO worksheet. If Yes, respond to #I-6.
I-6	If Yes to #I-5, does the State attest to applying different levels of FRs to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed for M/S benefits or for MH or SUD benefits per the special rule for multi-tiered prescription drugs at 42 CFR § 438.910(c)(2)(i)?	Dropdown	Yes	If No, complete the FR-MCO worksheet and describe why the State could not answer "Yes" in the Issues for Discussion-MCO worksheet.
I-7	If Yes to #I-6, describe the reasonable factor(s) (e.g., cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up/delivery) per the special rule for multi-tiered prescription drugs at 42 CFR § 438.910(c)(2)(i).	Free Text	Generic versus brand name, mail order versus pharmacy pick-up	If Yes to #I-6 and the State provided an explanation of reasonable factors, there is no need to complete the FR-MCO worksheet.
I-8	Does the State apply quantitative treatment limitation(s) (QTL) to any MH/SUD benefits in any benefit package and in any benefit classification?	Dropdown	No	If Yes, complete the QTL-MCO worksheet.
I-9	Does the State apply nonquantitative treatment limitation(s) (NQTL) to any MH/SUD benefits in any benefit package and in any benefit classification?	Dropdown	Yes	If Yes, complete the Intro NQTL-MCO and NQTL-MCO worksheets.

If a State applies QTLs (e.g., day limits) to MH/SUD benefits in any benefit package and in any benefit classification, the State should complete, as necessary based on the program type, the "L_QTL-MCO," "R_QTL-CHIP," and "X_QTL-ABP" worksheets.

There is conditional formatting incorporated so that if the State answers "No" to applying both ALs and ADLs, FRs, and/or QTLs for any program type, the corresponding worksheets will turn gray in their entirety to signify that no data entry is required. For example, if the State answers "No" to ID#s I-1-2 , the "J_AL-ADL-MCO worksheet" will turn gray as shown in Figure 8, and a message will appear in the top row indicating that the State should "SKIP THIS WORKSHEET."

Figure 8: Appearance of AL-ADL Worksheet if State All-Limits Worksheet Indicates No AL-ADLs

A	B	C	D	E	F	G	H
J. Aggregate Lifetime Dollar Limits and Annual Dollar Limits - MCO				SKIP THIS WORKSHEET PER I_ALL LIMITS-MCO RESPONSES I-1/I-2			
This section relates to AL/ADLs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.905. Refer to Instructional Guide section 2.8 for more detail.							
Question ID	Benefit Package	Entity Providing MH/SUD Benefits	Entity Providing M/S Benefits	Question	Response Type	Response	Response2
J-1				Describe the aggregate lifetime dollar limit (AL) or annual dollar limit (ADL) applied to MH/SUD benefits.	Free Text		
J-2				What is the percentage of all expected payments for all M/S benefits subject to the AL or ADL in a contract year?	Percentage (Enter decimal Rounds up to the nearest 100th)		
J-3				Does the AL or ADL apply to less than 1/3 of all M/S benefits?	Dropdown		
J-4				If No to #J-3, does the AL or ADL apply to at least 2/3 of all M/S benefits?	Dropdown		
J-5				If Yes to #J-4, can the State attest that it applies the AL or ADL to both M/S and MH/SUD benefits in a manner that does not distinguish between the types of benefits?	Dropdown		
J-6				If Yes to #J-4 and No to #J-5, can the State attest that it does not apply the AL or ADL to MH/SUD benefits that is more restrictive than for M/S benefits?	Dropdown		
J-7				If No to #J-3 and #J-4 (i.e., AL or ADL applies to something other than less than 1/3 of all M/S benefits or at least 2/3 of all M/S benefits), can the State demonstrate that it imposes the AL or ADL on MH/SUD benefits that is no more restrictive than an average limit calculated for M/S benefits using the weighted average of the AL or ADL, as appropriate, that are applicable to the categories of M/S benefits?	Dropdown		
J-8				If Yes to #J-7, what is the average limit, based on the weighted average of the AL or ADL, as appropriate, that is applicable to the categories of M/S benefits?	Free text		
J-1				Describe the aggregate lifetime dollar limit (AL) or annual dollar limit	Free Text		

Lastly, if a State applies any NQTLs to MH/SUD benefits in any benefit package and in any benefit classification, it should complete, as necessary based on the program type, the Intro NQTL and NQTL worksheets.

2.8 Aggregate Lifetime and Annual Dollar Limits (Medicaid MCO)

2.8.1 Regulatory basis for the worksheet

Medicaid MCO: 42 CFR § 438.905.

CHIP: This worksheet is not applicable to CHIP per 42 CFR § 457.480.

ABP: This worksheet is not applicable to ABPs because the ABP parity regulations at 42 CFR §440.395 do not include provisions related to AL-ADLs.[29]

2.8.2 Overall Layout

The State should complete the set of questions in the "J_AL-ADL-MCO" worksheet by benefit package within the MCO program type. For example, if there are two benefit packages (e.g., Benefit Package 1 and Benefit Package 2), the State will complete the same set of questions (IDs# 1-8) twice, once for Benefit Package 1, and again for Benefit Package 2. The State should select the benefit package described in the Benefit Package Column (Column B) using the drop-down options for benefit packages available in ID# 1.[30] The benefit package can only be selected

[29] However, under 42 CFR § 440.395(c), "Annual or lifetime limits are not permissible in EPSDT benefits."

[30] These drop-down options are populated from benefit package data entered in the "C_MCO Program Data" and "E_ABP Program Data" worksheets. If there are errors with the drop-down options available in Column B, the state should refer to the "C_MCO Program Data" and "E_ABP Program Data" worksheets.

using ID# 1; once selected, it will automatically generate the same benefit package for IDs# 2-8 in Column B for one set of questions.

The State should indicate the entity(ies) providing MH and/or SUD benefits in the Entity Providing MH/SUD Benefits Column (Column C), and the entities providing M/S benefits in the Entity Providing M/S Benefits Column (Column D). Note that the State should enter information in Columns C and D manually. If multiple entities provide MH/SUD or M/S benefits within the same benefit package and apply the same limitations, it is acceptable to list all entities within the same fields for MH/SUD or M/S, respectively, and enter the information for IDs# 1-8. However, if the entities providing MH and SUD benefits are not the same, the State should separately enter the entity that provides MH benefits and the entity that provides SUD benefits to ensure that the limitations applied by such entities are separately compared to M/S benefits (i.e., ID#s 1-8 may need to be completed multiple times for the same benefit package). Below are examples to demonstrate how to populate this worksheet depending on the scenario.

- If MCO A and MCO B both provide MH/SUD and M/S benefits, and use the same AL within the benefit package, both MCOs can be entered in Columns C and D.
- If MCO A uses a different type of AL than MCO B, the question set (IDs# 1-8) should be answered once for MCO A and again, separately beginning on ID# 1 of the next question set, for MCO B.
  For example, if MCO A provides MH and M/S benefits, but State FFS provides SUD benefits and MCO A and State FFS apply the same AL to MH and SUD, respectively, then both MCO A and State FFS should be added to the Entity Providing MH/SUD Benefits Column (Column C), and MCO A should be entered in the Entity Providing M/S Benefits Column (Column D).
- If MCO A and State FFS apply distinct ALs to MH and SUD, then the question set (IDs# 1-8) should be answered once for MCO A in Column C, and again, separately beginning on ID# 1 of the next question set for State FFS in Column C. MCO A should remain in Column D for both question sets.
- If the same AL or ADL is applied by all entities to MH/SUD and/or M/S, then the State should enter "All" in Columns C and/or D.

All questions are in the Question Column (Column E), while Columns G-P relate to different types of ALs or ADLs, as applicable. The questions in Column E (ID# 1-8) should be answered for each type of AL or ADL indicated in response to ID# 1 across Columns G-P.

For example, if, for a benefit package, a State includes both an AL and ADL, it should enter the AL in ID# 1 Response Column (Column G), and the ADL in ID# 1 Response2 Column (Column H). In this example, all IDs# 1-8 should be answered for the AL in Column G, and answered again for all IDs# 1-8 for the ADL in Column H.

If, however, the State includes a different type of AL or ADL for two different benefit packages, it should respond to all IDs (IDs# 1-8) twice, once for the first benefit package and again, separately using the next question set, for the second benefit package (see Figure 9).

Figure 9: Example AL-ADL Worksheet with Multiple Benefit Packages with Distinct Limits

A B C D E F G

J. Aggregate Lifetime Dollar Limits and Annual Dollar Limits - MCO

This section relates to AL/ADLs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.905. Refer to Instructional Guide section 2.8 for more detail.

Question ID	Benefit Package	Entity Providing MH/SUD Benefits	Entity Providing M/S Benefits	Question	Response Type	Response
J-1	Benefit Package 1-MCO	All	All	Describe the aggregate lifetime dollar limit (AL) or annual dollar limit (ADL) applied to MH/SUD benefits.	Free Text	$1,000,000 AL on XYZ services
J-2	Benefit Package 1-MCO	All	All	What is the percentage of all expected payments for all M/S benefits subject to the AL or ADL in a contract year?	Percentage (Enter decimal. Rounds up to the nearest 100th)	0.00%
J-3	Benefit Package 1-MCO	All	All	Does the AL or ADL apply to less than 1/3 of all M/S benefits?	Dropdown	Yes
J-4	Benefit Package 1-MCO	All	All	If No to #J-3, does the AL or ADL apply to at least 2/3 of all M/S benefits?	Dropdown	
J-5	Benefit Package 1-MCO	All	All	If Yes to #J-4, can the State attest that it applies the AL or ADL to both M/S and MH/SUD benefits in a manner that does not distinguish between the types of benefits?	Dropdown	
J-6	Benefit Package 1-MCO	All	All	If Yes to #J-4 and No to #J-5, can the State attest that it does not apply the AL or ADL to MH/SUD benefits that is more restrictive than for M/S benefits?	Dropdown	
J-7	Benefit Package 1-MCO	All	All	If No to #J-3 and #J-4 (i.e., AL or ADL applies to something other than less than 1/3 of all M/S benefits or at least 2/3 of all M/S benefits), can the State demonstrate that it imposes the AL or ADL on MH/SUD benefits that is no more restrictive than an average limit calculated for M/S benefits using the weighted average of the AL or ADL, as appropriate, that are applicable to the categories of M/S benefits?	Dropdown	
J-8	Benefit Package 1-MCO	All	All	If Yes to #J-7, what is the average limit, based on the weighted average of the AL or ADL, as appropriate, that is applicable to the categories of M/S benefits?	Free text	
J-1	Benefit Package 2-MCO			Describe the aggregate lifetime dollar limit (AL) or annual dollar limit (ADL) applied to MH/SUD benefits.	Free Text	$100,000 ADL on ABC services

2.8.3 Instructions

As discussed, the State should describe the type of AL or ADL in ID# 1. The questions that follow in IDs# 2-8 correspond with the Federal parity regulations for ALs and ADLs at 42 CFR § 438.905. Note that, if the State indicates that multiple entities provide M/S benefits (i.e., more than one managed care plan or delivery system in the Entity Providing M/S Benefits Column (Column D)), the percentage of all expected payments for M/S benefits subject to the AL or ADL in a contract year (ID# 2) will be an aggregate percentage based on the respective entities' cost analyses. The State should enter a percentage for ID# 2, as no other response format is acceptable. The remaining questions are related to if this percentage is less than 33.3% of all M/S benefits; more than 66.7% of all M/S benefits; or equal to or more than 33.3% while equal to or less than 66.7% of all M/S benefits.

This worksheet contains conditional formatting to guide the State as to which questions should be answered based on previous responses. For example, if the State selects "No" in ID#s 3 and 4 to indicate that the AL or ADL applies to more than 1/3 but less than 2/3 of all M/S benefits, then IDs# 5 and 6 will turn gray to indicate that no response is necessary for those IDs.

Pop-up boxes will appear over the questions in the Question Column (Column E) when clicking on a cell in which there may be an issue for discussion (see Figure 10 for an example). If there is an issue for discussion based on the State's responses to these questions, the State should indicate the issue on the Issues for Discussion worksheet ('O_Issues for Discussion-MCO').

Figure 10: Example AL-ADL Worksheet with Pop-up Box Flagging an Issue for Discussion

E F G

O

rdance with 42 CFR § 438.905. Refer to Instructional Guide section 2.8 for more detail.

Question	Response Type	Response
Describe the aggregate lifetime dollar limit (AL) or annual dollar limit (ADL) applied to MH/SUD benefits.	Free Text	$1,000,000 AL on XYZ services
What is the percentage of all expected payments for all M/S benefits subject to the AL or ADL in a contract year?	Percentage (Enter decimal. Rounds up to the nearest 100th)	0.00%
Does the AL or ADL apply to less than 1/3 of all M/S benefits?	Dropdown	Yes
If No to #J-3, does the AL or ADL a S benefits?	Dropdown	
If Yes to #J-4, can the State attest t L to both M/S and MH/SUD benefits in a mar sh between the types of benefits?	Dropdown	
If Yes to #J-4 and No to #J-5, can t not apply the AL or ADL to MH/SUD benefits that is more restrictive than for M/S benefits?	Dropdown	
If No to #J-3 and #J-4 (i.e., AL or ADL applies to something other than less than 1/3 of all M/S benefits or at least 2/3 of all M/S benefits), can the State demonstrate that it imposes the AL or ADL on MH/SUD benefits that is no more restrictive than an average limit calculated for M/S benefits using the weighted average of the AL or ADL, as	Dropdown	

If there is no cost analysis provided, or if AL or ADL is applied to less than 1/3 of all M/S benefits, there may be an issue requiring discussion. Please enter in the Issues for Discussion-MCO worksheet.

2.9 Financial Requirements (Medicaid MCO, CHIP, ABP)

2.9.1 Regulatory basis for the worksheets

Medicaid MCO: 42 CFR § 438.910(a)-(c)

CHIP: 42 CFR § 457.496(d)(1)-(3)

ABP: 42 CFR § 440.395(b)(1)-(3)

2.9.2 Overall Layout

The instructions for the "K_FR-MCO," "Q_FR-CHIP," and "W_FR-ABP" worksheets are the same and the questions in the worksheets (referred to as IDs# 1-7) follow the same logic. The State should complete the set of questions, as necessary, in the "K_FR-MCO," "Q_FR-CHIP," and "W_FR-ABP" worksheets by benefit package within the given program type. For example, if there are two benefit packages within CHIP, there should be one set of questions (IDs# 1-7) for each benefit package. The State should select the benefit package described in the Benefit Package Column (Column B) using the drop-down options for benefit packages available in ID#

1.[31] The benefit package can only be selected using ID# 1; once selected, it will automatically generate the same benefit package for IDs# 2-7 in Column B for one set of questions.

The State should indicate the entity(ies) providing MH and/or SUD benefits in the Entity Providing MH/SUD Benefits Column (Column C), and the entity(ies) providing M/S benefits in the Entity Providing M/S Benefits Column (Column D). Note that States should enter information in Columns C and D manually. If multiple entities provide MH/SUD or M/S benefits within the same benefit package and apply the same limitations, it is acceptable to list all entities within the same fields for MH/SUD and M/S, respectively, and enter the information for IDs# 1-7. However, if the entities providing MH and SUD benefits are not the same, the State should separately enter the entity that provides MH benefits and the entity that provides SUD benefits to ensure that the FRs applied by such entities are separately compared to M/S benefits (i.e., ID#s 1-7 may need to be completed multiple times for the same benefit package). Below are examples to demonstrate how to populate the worksheet depending on the scenario.

- If MCO A and MCO B both provide MH/SUD and M/S benefits and use the **same** FRs (e.g., copayments) for the benefit package, both MCOs can be entered in Columns C and D.
- If MCO A uses copayments and MCO B uses both copayments and coinsurance, the State should complete the question set (IDs# 1-7) once for MCO A and again for MCO B using the next question set (numbered again as IDs# 1-7).
- If MCO A provides MH and M/S benefits, but State FFS provides SUD benefits, and MCO A and State FFS apply the same FR to MH and SUD, respectively, both MCO A and State FFS would be added to Column C, and MCO A would be entered in Column D.
- If MCO A and State FFS apply distinct FRs to MH and SUD, then the question set (IDs# 1-7) should be answered once with MCO A in Column C, and again with State FFS in Column C for the next question set (numbered again as IDs# 1-7). MCO A would remain in Column D for both question sets.

See Figure 11 for an example of how distinct FRs should be entered into the worksheet.

[31] These drop-down options are populated from data in the "C_MCO Program Type Data," "D_CHIP Program Type Data," and "E_ABP Program Type Data" worksheets. If there are errors with the drop-down options available in Column B, the state should refer to the "C_MCO Program Data," "D_CHIP Program Data," and "E_ABP Program Data" worksheets.

Figure 11: Example FR worksheet with Entities Applying Distinct FRs in the Same Benefit Package

K. Financial Requirements - MCO

This section relates to FRs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(a)-(c).Refer to Instructional Guide section 2.9 for more detail.

A	B	C	D	E	F	G	H
Question ID	Benefit Package	Entity Providing MH/SUD Benefi	Entity Providing M/S Benefits	Benefit Classificati	Question	Response Type	Response
K-1	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	Indicate the type of financial requirement (FR) (e.g., copayment, coinsurance, deductible) that applies to MH/SUD benefits in this classification using the applicable column(s).	Free text	Copayment
K-2	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	Describe the level (i.e., magnitude) of FR (e.g., $5 or 10%) that applies to MH/SUD benefits in this classification and the service to which the FR is applied (e.g., primary care visit) using the applicable column(s).	Free text	$1 per primary care visit
K-3	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	Is the FR applied to MH/SUD benefits identical to or less restrictive than the **same** FR applied to M/S benefits in this classification?	Dropdown	No
K-4	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	If Yes to #K-3, describe how the FR applied to MH/SUD benefits is identical to or less restrictive than the FR applied to M/S benefits in this classification.	Free text	
K-5	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	If no to #K-3, what is the percentage of all expected payments for M/S benefits subject to the FR in a contract year?	Percentage (Enter decimal. Rounds up to the nearest 100th)	60.00%
K-6	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	If the percentage in #K-5 is 66.7% or greater, what is the predominant level of the FR for M/S benefits in this classification subject to this type of FR? The predominant level is either a single level of the FR that applies to at least 50% of M/S benefits in the classification subject to this type of FR, or the least restrictive level within a combination of levels used to reach 50% of M/S benefits in the classification subject to	Free text	
K-7	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	Is the predominant level in #K-6 a single level of the FR that applies to more than 50% of M/S benefits in the classification subject to this type of FR, or the least restrictive level within a combination of levels of the FR used to reach 50% of M/S benefits in this classification subject to this type of FR?	Dropdown	
K-1	Benefit Package 1-MCO	State FFS	MCO A	Inpatient	Indicate the type of financial requirement (FR) (e.g., copayment, coinsurance, deductible) that applies to MH/SUD benefits in this classification using the applicable column(s).	Free text	Copayment
K-2	Benefit Package 1-MCO	State FFS	MCO A	Inpatient	Describe the level (i.e., magnitude) of FR (e.g., $5 or 10%) that applies to MH/SUD benefits in this classification and the service to which the FR is applied	Free text	$8 per inpatient admission

Each question set (IDs# 1-7) relates to one benefit classification only. In the Benefit Classification Column (Column E), the State should select (from the drop-down options) the benefit classification in which the FRs are applied. Note that a benefit classification can only be selected using ID# 1; once selected, it will automatically generate the same benefit classification for IDs# 2-7 in Column E for one set of questions. If FRs are applied in the inpatient and outpatient benefit classifications, the State should complete the question set (IDs# 1-7) once for the inpatient classification and again for the outpatient classification using the next question set (numbered again as IDs# 1-7).

All questions are in Question Column (Column F) while Columns H-Q are for responses that relate to ***different types of FRs*** (e.g., copayments, coinsurance, deductibles), as applicable. The questions in Column F (IDs# 1-7) should be answered for each type of FR indicated in response to ID# 1 across Columns H-Q. If the State has more than 10 types of FRs, it should complete an additional Template. For example, if a State or managed care plan includes both copayments and coinsurance, the State should enter the copayments in ID# 1 Response Column (Column H), and the coinsurance in ID# 1, Response2 Column (Column I). An additional example is if a State has copayments for enrollees with income level of 100-199% Federal Poverty Limit (FPL) and different copayments for enrollees with income level of 200-299% FPL. In this case, the State

should enter the copayments that apply to enrollees with income level of 100-199% FPL in Response Column (Column H), and the copayments that apply to enrollees with income level of 200-299% FPL in Response Column (Column I) (see Figure 12).

Figure 12: Example FR Worksheet Showing How to Enter Multiple Income-based Copayments

E	F	G	H	I
:aid MCOs in accordance with 42 CFR § 438.910(a)-(c).Refer to Instructional Guide section 2.9 for more detail.				
Benefit Classification	**Question**	**Response Type**	**Response**	**Response2**
Inpatient	Indicate the type of financial requirement (FR) (e.g., copayment, coinsurance, deductible) that applies to MH/SUD benefits in this classification using the applicable column(s).	Free text	Copayment on beneficiaries with income level between 100-199% FPL	Copayment on beneficiaries with income level between 200-299% FPL
Inpatient	Describe the level (i.e., magnitude) of FR (e.g., $5 or 10%) that applies to MH/SUD benefits in this classification and the service to which the FR is applied (e.g., primary care visit) using the applicable column(s).	Free text	$5 per inpatient admission	$8 per inpatient admission

2.9.3 Instructions

As discussed, the State should indicate the type of FR ***that applies to MH/SUD benefits*** in ID# 1. For example, the State should indicate 'copayments' in ID# 1, Question Column (Column F), if there are copayments that apply to MH/SUD benefits – within a benefit package, benefit classification, and for an entity (or entities) that provide MH/SUD benefits. In ID# 2, the State should then indicate the level or magnitude of the FR indicated in ID# 1.[32] For example, the copayments may be $5 for an outpatient primary care visit; $5 is the level of the copayment. In ID# 2, the State should enter both the level of the FR and the service to which it applies.

The next two questions (IDs# 3-4) are intended to streamline the State's parity documentation, if applicable. If the State can attest in ID# 3 that the type of FR applied for MH/SUD benefits in the classification is either identical to or less restrictive than the same FR applied for M/S benefits in the classification – and provides a description of how this is the case in ID# 4 – it does not need to answer the remaining questions in the set (IDs# 5-7).[33] For example, if the copayment for both a MH/SUD and M/S inpatient admission is $8 in a benefit package and across all managed care plans that provide MH/SUD and M/S benefits in that benefit package, then the copayments for MH/SUD and M/S inpatient admissions are identical. The copayment for an inpatient admission in this example is applied uniformly regardless of whether a MH/SUD or M/S services is involved. Thus, the State does not need to complete IDs# 5-7. Conditional formatting is built into the worksheet to "gray out" IDs# 5-7 if the State responds 'Yes' to ID# 3 (see Figure 13)

[32] 42 CFR § 438.910(a)(3), 42 CFR § 457.496(d)(1)(iii), 42 CFR § 440.395(b)(1)(iii) for MCO, CHIP, and ABP, respectively.

[33] See Tip 5a, p. 22 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

Figure 13: Example FR Worksheet Showing Conditional Formatting based on Responses

K. Financial Requirements - MCO

This section relates to FRs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(a)-(c).Refer to Instructional Guide section 2.9 for more detail.

Question ID	Benefit Package	Entity Providing MH/SUD Benefi	Entity Providing M/S Benefits	Benefit Classificati	Question	Response Type	Response
K-1	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	Indicate the type of financial requirement (FR) (e.g., copayment, coinsurance, deductible) that applies to MH/SUD benefits in this classification using the applicable column(s).	Free text	Copayment
K-2	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	Describe the level (i.e., magnitude) of FR (e.g., $5 or 10%) that applies to MH/SUD benefits in this classification and the service to which the FR is applied (e.g., primary care visit) using the applicable column(s).	Free text	$10 per primary care visit
K-3	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	Is the FR applied to MH/SUD benefits identical to or less restrictive than the **same** FR applied to M/S benefits in this classification?	Dropdown	Yes
K-4	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	If Yes to #K-3, describe how the FR applied to MH/SUD benefits is identical to or less restrictive than the FR applied to M/S benefits in this classification.	Free text	The $10 copayment applies to primary care visits regardless if for MH/SUD or M/S conditions.
K-5	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	If no to #K-3, what is the percentage of all expected payments for M/S benefits subject to the FR in a contract year?	Percentage (Enter decimal. Rounds up to the nearest 100th)	
K-6	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	If the percentage in #K-5 is 66.7% or greater, what is the predominant level of the FR for M/S benefits in this classification subject to this type of FR? The predominant level is either a single level of the FR that applies to at least 50% of M/S benefits in the classification subject to this type of FR, or the least restrictive level within a combination of levels used to reach 50% of M/S benefits in the classification subject to	Free text	
K-7	Benefit Package 1-MCO	MCO A	MCO A	Outpatient	Is the predominant level in #K-6 a single level of the FR that applies to more than 50% of M/S benefits in the classification subject to this type of FR, or the least restrictive level within a combination of levels of the FR used to reach 50% of M/S benefits in this classification subject to this type of FR?	Dropdown	

If the State cannot attest that the type of FR applied for MH/SUD benefits in the classification is either identical to or less restrictive than the same FR applied for M/S benefits in the classification, and if the State cannot describe how this is the case, it should complete the remaining questions in the set (IDs# 5-7) to demonstrate compliance with the "substantially all" and "predominant" cost analysis two-part test.[34]

In ID# 5, the State indicates the percentage of total payments for M/S benefits subject to the type of FR (as listed across Columns H-M, as applicable) in the benefit classification in a contract year. Note that, if the State indicated that multiple entities provide M/S benefits (i.e., more than one managed care plan in Column D), the percentage of all expected payments for M/S benefits subject to the FR in a contract year (ID# 5) will be an aggregate percentage based on the respective entities' cost analyses. The State should enter a percentage for ID# 5, as no other response format is acceptable.

If the percentage in ID# 5 is less than 66.7%, the FR cannot be applied to MH/SUD benefits in the benefit classification,[35] and IDs# 6-7 will turn gray. If the FR is still applied to MH/SUD

[34] See Section 5.2, p. 22-25 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

[35] 42 CFR § 438.910(b)(1), 42 CFR § 457.496(d)(2), 42 CFR § 440.395(b)(2)(i), for MCO, CHIP, and ABP, respectively.

benefits when the percentage in ID# 5 is less than 66.7%, the State should note it in the Issues for Discussion worksheet.

If the percentage in ID# 5 is 66.7% or greater, the State should enter the predominant level of the FR in ID# 6. The predominant level is the level of the FR (e.g., $5) that applies to more than half of all M/S benefits in the classification. For the predominant level provided in response to ID# 6, the State should indicate using the drop-down options for the response to ID# 7 if it used a single level of the FR that applies to more than 50% of M/S benefits subject to this type of FR ("Single Level") or if it used the least restrictive level within a combination of levels of the FR that the State used to reach 50% of M/S benefits subject to this type of FR in this classification ("Least restrictive within a combination of levels").[36] If the predominant level in ID#6 is neither a single level nor the least restrictive level within a combination of levels of the FR, the State should describe the predominant level in the applicable Issues for Discussion worksheet. If the State applies a level of the FR to MH/SUD benefits that is more restrictive than this predominant level of FR, it should describe it in the applicable Issues for Discussion worksheet.

Note that the worksheet includes conditional formatting to guide the State as to which questions it should answer based on its previous responses. For example, if the State selects "Yes" in ID# 3 to indicate that the FR applied to MH/SUD benefits is identical to or less restrictive than the FR applied to M/S benefits in the classification, it should still respond to ID# 4, but IDs# 5-7 will automatically turn gray to indicate that no response is necessary in IDs# 5-7.

Pop-up boxes will appear over Question Column (Column F) questions when clicking on a cell in which there may be an issue for discussion (see Figure 14 for an example). If there is an issue for discussion based on the State's responses to these questions, the State should indicate the issue on the Issues for Discussion worksheets ("O_Issues for Discussion-MCO," "U_Issues for Discussion-CHIP", or "AA_Issues for Discussion-ABP").

[36] 42 CFR § 438.910(c)(1)(ii), 42 CFR § 457.496(d)(3)(i)(B), 42 CFR § 440.395(b)(3)(i)(B) for MCO, CHIP, and ABP respectively.

Figure 14: Example FR Worksheet Showing Pop-up Box Flagging an Issue for Discussion

E	F	G	H

id MCOs in accordance with 42 CFR § 438.910(a)-(c).Refer to Instructional Guide section 2.9 for more detail.

Benefit Classification	Question	Response Type	Response
Outpatient	Indicate the type of financial requirement (FR) (e.g., copayment, coinsurance, deductible) that applies to MH/SUD benefits in this classification using the applicable column(s).	Free text	Copayment
Outpatient	Describe the level (i.e., magnitude) of FR (e.g., $5 or 10%) that applies to MH/SUD benefits in this classification and the service to which the FR is applied (e.g., primary care visit) using the applicable column(s).	Free text	$10 per primary care visit
Outpatient	Is the FR applied to MH/SUD benefits identical to or less restrictive than the **same** FR applied to M/S benefits in this classification?	Dropdown	No
Outpatient	If Yes to #K-3, describe how the FR applied to MH/SUD benefits is identical to or less restrictive than the FR applied to M/S benefits in this classification.	Free text	
Outpatient	If no to #K-3, what is the percentage of all expected payments for M/S benefits subject to the FR in a contract year?	Percentage (Enter decimal. Rounds up to the nearest 100th)	60.00%
Outpatient	If the percentage in #K-5 is 66 [illegible] predominant level of the FR f[illegible] classification subject to this t[illegible] level is either a single level of [illegible] least 50% of M/S benefits in t[illegible] this type of FR, or the least re[illegible] combination of levels used to reach 50% of M/S benefits in the classification subject to this type of FR.	Free text	
Outpatient	Is the predominant level in #K-6 a single level of the FR that applies to more than 50% of M/S benefits in the classification subject to this type of FR, or the least restrictive level within a combination of levels of the FR used to reach 50% of M/S benefits in this classification subject to this type of FR?	Dropdown	

If there is no cost analysis provided, or if the percentage is less than 2/3, there may be an issue requiring discussion. Please enter in the Issues for Discussion-MCO worksheet.

2.10 Quantitative Treatment Limitations (Medicaid MCO, CHIP, ABP)

2.10.1 Regulatory basis for the worksheets

Medicaid MCO: 42 CFR § 438.910(a)-(c)

CHIP: 42 CFR § 457.496(d)(1)-(3)

ABP: 42 CFR § 440.395(b)(1)-(3)

2.10.2 Overall Layout

The instructions for the "L_QTL-MCO," "R_QTL-CHIP," and "X_QTL-ABP" worksheets are the same and the questions in the worksheets (referred to as IDs# 1-7) follow the same logic. The State should complete the set of questions, as necessary, in these worksheets by benefit package within the given program type. For example, if there are three benefit packages, there should be one set of questions (IDs# 1-7) for each benefit package. The State should select the benefit package described in the Benefit Package Column (Column B) using the drop-down options for benefit packages available in ID# 1.[37] Note that the benefit package can only be selected using ID# 1; once selected, it will automatically generate the same benefit package for IDs# 2-7 in Column B for one set of questions.

The State should indicate the entity(ies) providing MH and/or SUD benefits in the Entity Providing MH/SUD Benefits Column (Column C) and the entity(ies) providing M/S benefits in the Entity Providing M/S Benefits Column (Column D). Note that States should enter information in Columns C and D manually. If multiple entities provide MH/SUD or M/S benefits within the same benefit package and apply the same limitations, it is acceptable to list all entities within the same fields for MH/SUD and M/S, respectively, and enter the information for IDs# 1-7. However, if the entities providing MH and SUD benefits are not the same, the State should separately enter the entity that provides MH benefits and the entity that provides SUD benefits to ensure that the QTLs applied by such entities are separately compared to M/S benefits (i.e., ID#s 1-7 may need to be completed multiple times for the same benefit package). Below are examples to demonstrate how to populate the worksheet depending on the scenario.

- If MCO A and MCO B both provide MH/SUD and M/S benefits, and use the ***same*** QTLs (e.g., episode limits) within the benefit package, both MCOs can be entered in Columns C and D.
- If MCO A uses episode limits and MCO B uses both episode limits and day limits, the State should complete the question set (IDs# 1-7) once for MCO A and again for MCO B in the next question set (numbered again as IDs# 1-7).
- If MCO A provides MH and M/S benefits, but State FFS provides SUD benefits and MCO A and State FFS apply the same QTL to MH and SUD, respectively, then both MCO A and State FFS would be added to the Entity Providing MH/SUD Benefits Column (Column C), and MCO A would be entered in the Entity Providing M/S Benefits (Column D).
- If MCO A and State FFS apply distinct QTLs to MH and SUD, then the question set (IDs# 1-7) needs to be answered once for MCO A in Column C, and again for State FFS in Column C in the next question set (numbered again as IDs# 1-7). MCO A would remain in Column D for both question sets.

[37] These drop-down options are populated from data in the "C_MCO Program Type Data," "D_CHIP Program Type Data," and "E_ABP Program Type Data" worksheets. If there are errors with the drop-down options available in Column B, the state should refer to the "C_MCO Program Data," "D_CHIP Program Data," and "E_ABP Program Data" worksheets.

- If the same AL or ADL is applied by all entities to MH/SUD and/or M/S, then the State should enter 'All' in Columns C and/or D.

Each set of questions (IDs# 1-7) relates to one benefit classification only. In the Benefit Classification Column (Column E), the State should select (from the drop-down options) the benefit classification in which the QTLs are applied. Note that a benefit classification can only be selected using ID# 1; once selected, it will automatically generate the same benefit classification for ID#s 2-7 in Column E for one set of questions. If QTLs are applied in the inpatient and outpatient benefit classifications, the State should complete the question set (IDs# 1-7) once for the inpatient classification and again for the outpatient classification in the next question set (numbered again as IDs# 1-7).

All questions are in the Question Column (Column F), while Columns H-Q are for responses that relate to ***different types of QTLs*** (e.g., episode, day, or visit limits). The questions in the Question Column (Column F) (IDs# 1-7) should be answered for each type of QTL indicated in response to ID# 1 across columns H-Q. If the State has more than 10 types of QTLs, it should complete an additional Template. For example, if a State includes both day limits and visit limits, the State should enter the day limits in ID# 1 Response Column (Column H), and the visit limits in ID# 1, Column I.

2.10.3 Instructions

As discussed, the State should indicate the type of QTL that applies to MH/SUD benefits in ID# 1. For example, the State should indicate 'day limits' in ID# 1, Response Column (Column H), if there are day limits that apply to MH/SUD benefits – within a benefit package, benefit classification, and for an entity (or entities) that provide MH/SUD benefits. Note that QTLs are numerical limitations on benefits that cannot be exceeded by medical necessity criteria; in other words, there is no process by which the enrollee can exceed the numerical limitation. If the entity providing benefits allows the enrollee to exceed the numerical limitation based on a medical necessity determination or some other process, this would be an NQTL and should be entered in the NQTL worksheets.[38]

In ID# 2, the State should then indicate the level or magnitude of the QTL in ID# 1.[39] For example, if there is a 90-day limit for SUD residential treatment, 90 days is the level of the day limit QTL. In ID# 2, the State should enter both the level of the QTL and the service to which it applies.

The next two questions (IDs# 3-4) are intended to streamline the State's parity documentation, if applicable. If the State can attest in ID# 3 that the QTL applied for MH/SUD benefits in the classification is either identical to or less restrictive than the same QTL applied for M/S benefits

[38] See Section 6.1, p. 34 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

[39] 42 CFR § 438.910(a)(3), 42 CFR § 457.496(d)(1)(iii), 42 CFR § 440.395(b)(1)(iii) for MCO, CHIP, and ABP, respectively.

in the classification – and provides a description of how this is the case in ID# 4 – it does not need to complete the remaining questions in the set (IDs# 5-7).[40]

If the State cannot attest that the QTL applied for MH/SUD benefits in the classification is either identical to or less restrictive than the same QTL applied for M/S benefits in the classification, and it cannot provide a description of how this is the case, it should complete the remaining questions in the set (IDs# 5-7) to demonstrate compliance with the "substantially all" and "predominant" cost analysis two-part test.

See Figure 15 for an example of how the conditional formatting for IDs# 5-7 will present depending on the State's response to ID# 3.

Figure 15: Example QTL Worksheet Showing Conditional Formatting based on Responses

A	B	C	D	E	F	G	H	I
L. Quantitative Treatment Limitations - MCO								
This section relates to QTLs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(a)-(c). Refer to Instructional Guide section 2.10 for more detail.								
Question ID	Benefit Package	Entity Providing MH/SUD	Entity Providing M/S Benefits	Benefit Classification	Question	Response Type	Response	Response2
L-1	Benefit Package 1-MCO	All	All	Inpatient	Indicate the type of quantitative treatment limit (QTL) (e.g., visit limitation, day limitation, hour limitation, expenditure limitation, waiting periods) that applies to MH/SUD benefits in this classification using the applicable column(s).	Free text	Day limitation	Visit Limitation
L-2	Benefit Package 1-MCO	All	All	Inpatient	Describe the level (i.e., magnitude) of QTL (e.g., 20 visit limit) that applies to MH/SUD benefits in this classification and the service to which the QTL is applied (e.g., primary care visit) using the applicable column(s).	Free text	30 days per SUD admission	25 psychotherapy visits for non-SMI
L-3	Benefit Package 1-MCO	All	All	Inpatient	Is the QTL applied to MH/SUD benefits identical to or less restrictive than the **same** QTL applied to M/S benefits in this classification?	Dropdown	No	Yes
L-4	Benefit Package 1-MCO	All	All	Inpatient	If Yes to #L-3, describe how the QTL applied to MH/SUD benefits is identical to or less restrictive than the QTL applied to M/S benefits in this classification.	Free text		Less restrictive than the 20 visit limit for PT/ST/OT
L-5	Benefit Package 1-MCO	All	All	Inpatient	If No to #L-3, what is the percentage of all expected payments for M/S benefits subject to the QTL in a contract year?	Percentage (Enter decimal. Rounds up to the nearest 100th)	0.00%	
L-6	Benefit Package 1-MCO	All	All	Inpatient	If the percentage in #L-5 is 66.7% or greater, what is the predominant level of the QTL for M/S benefits in this classification subject to this type of QTL? The predominant level is either a single level of the QTL that applies to at least 50% of M/S benefits in the classification subject to this type of QTL, or the least restrictive level within a combination of levels used to reach 50% of M/S benefits in the classification subject to this type of QTL.	Free text		
L-7	Benefit Package 1-MCO	All	All	Inpatient	Is the predominant level in #L-6 a single level of the QTL that applies to more than 50% of M/S benefits in the classification subject to this type of QTL, or the least restrictive level within a combination of levels of the QTL used to reach 50% of M/S benefits	Dropdown		

In ID# 5, the State indicates the percentage of total payments of M/S benefits subject to the type of QTL (as listed across Columns G-L, as applicable) in the benefit classification in a contract year. Note that, if the State indicated that multiple entities provide M/S benefits (i.e., more than one managed care plan in Column D), the percentage of all expected payments for all M/S benefits subject to the QTL in a contract year (ID# 5) will be an aggregate percentage based on the respective entities' cost analyses. The State should enter a percentage for ID# 5, as no other response format is acceptable.

[40] See Tip 5a, p. 22 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

If the percentage in ID# 5 is less than 66.7% then IDs# 6-7 will turn gray because the QTL cannot be applied to MH/SUD benefits in the benefit classification.[41] If the QTL is still applied to MH/SUD benefits when the percentage in ID# 5 is less than 66.7%, the State should describe why in the Issues for Discussion worksheet.

If the percentage in ID#5 is 66.7% or greater, the State should enter the predominant level of the QTL in ID#6. The predominant level is the level of the QTL (e.g., 90-day limit) that applies to more than half of M/S benefits subject to this type of QTL in the classification. For the predominant level provided in response to ID#6, the State should indicate using the drop-down options for the response to ID#7 if it used a single level of the QTL that applies to more than 50% of M/S benefits subject to this type of QTL ("Single Level") or if it used the least restrictive level within a combination of levels of the QTL that the State used to reach 50% of M/S benefits subject to this type of QTL in this classification ("Least restrictive within a combination of levels").[42] If the predominant level entered in ID#6 is neither a single level nor the least restrictive level within a combination of levels of the QTL, the State should describe the predominant level in the applicable Issues for Discussion worksheet. If the State applies a level of the QTL to MH/SUD benefits that is more restrictive than this predominant level of QTL, the State should describe it in the applicable Issues for Discussion worksheet.

The worksheet includes conditional formatting to guide the State as to which questions it should answer based on its previous responses. For example, if the State selects "Yes" in ID #3 to indicate that the QTL applied to MH/SUD benefits is identical to or less restrictive than the QTL applied to M/S benefits in the classification, it should still respond to ID #4, but IDs# 5-7 will automatically turn gray to indicate that no response is necessary in IDs# 5-7.

Pop-up boxes will appear over the Question Column (Column F) questions when clicking on a cell in which there may be an issue for discussion (see Figure 16 for an example). If there is an issue for discussion based on the State's responses to these questions, the State should indicate the issue on the Issues for Discussion worksheets ("O_Issues for Discussion-MCO," "U_Issues for Discussion-CHIP", or "AA_Issues for Discussion-ABP").

[41] 42 CFR § 438.910(b)(1), 42 CFR § 457.496(d)(2), 42 CFR § 440.395(b)(2)(i), for MCO, CHIP, and ABP, respectively.
[42] 42 CFR § 438.910(c)(1)(ii), 42 CFR § 457.496(d)(3)(i)(B), 42 CFR § 440.395(b)(3)(i)(B) for MCO, CHIP, and ABP respectively.

Figure 16: Example QTL Worksheet Showing Pop-up Box Flagging an Issue for Discussion

E	F	G	H
s of Medicaid MCOs in accordance with 42 CFR § 438.910(a)-(c). Refer to Instructional Guide section 2.10 for more			
Benefit Classification	**Question**	**Response Type**	**Response**
Inpatient	Indicate the type of quantitative treatment limit (QTL) (e.g., visit limitation, day limitation, hour limitation, expenditure limitation, waiting periods) that applies to MH/SUD benefits in this classification using the applicable column(s).	Free text	Day limitation
Inpatient	Describe the level (i.e., magnitude) of QTL (e.g., 20 visit limit) that applies to MH/SUD benefits in this classification and the service to which the QTL is applied (e.g., primary care visit) using the applicable column(s).	Free text	30 days per SUD admission
Inpatient	Is the QTL applied to MH/SUD benefits identical to or less restrictive than the **same** QTL applied to M/S benefits in this classification?	Dropdown	No
Inpatient	If Yes to #L-3, describe how the QTL applied to MH/SUD benefits is identical to or less restrictive than the QTL applied to M/S benefits in this classification.	Free text	
Inpatient	If No to #L-3, what is the percentage of all expected payments for M/S benefits subject to the QTL in a contract year?	Percentage (Enter decimal. Rounds up to the nearest 100th)	0.00%
Inpatient	If the percentage in #L-5 is the predominant level of th this classification subject t predominant level is either that applies to at least 50% classification subject to thi restrictive level within a combination of levels used to reach 50% of M/S benefits in the classification subject to this type of QTL.	Free text	
Inpatient	Is the predominant level in #L-6 a single level of the QTL that applies to more than 50% of M/S benefits in the classification subject to this type of QTL, or the least restrictive level within a combination of levels of the QTL used to reach 50% of M/S benefits in this classification subject to this type of QTL?	Dropdown	

If there is no cost analysis provided, or if the percentage is less than 2/3, there may be an issue requiring discussion. Please enter in the Issues for Discussion-MCO worksheet.

2.11 Introduction – Nonquantitative Treatment Limitations (Medicaid MCO, CHIP, ABP)

2.11.1 Overall Layout

The Intro NQTL worksheets ("M_Intro NQTL-MCO," "S_Intro NQTL-CHIP," and "Y_Intro NQTL-ABP") require the State to provide an overview of how all NQTLs are applied to MH and/or SUD benefits within all benefit packages, by all entities providing benefits, and in all benefit classifications, as applicable based on the State's program types. The instructions and layout for these worksheets are the same.

The Intro NQTL worksheets include two parts: "Step-1: Highlighted NQTLs" and "Step 2 – Other NQTLs." Both parts should be completed, as States are required to assess all NQTLs for compliance with parity requirements. States will complete additional analysis, as described below, for the highlighted NQTLs:

1. Prior Authorization
2. Concurrent Review
3. Step Therapy/Fail First
4. Standards for Provider Network Admission *(only required for analyses that include one or more entity(ies) establishing a provider network, separate from the FFS network)*
5. Standards for Access to Out-of-Network Care *(only required for analyses that include one or more entity(ies) establishing a provider network, separate from the FFS network)*

For all other NQTLs applied to MH and/or SUD benefits in the State (i.e., excluding the five highlighted NQTLs), States should attest to whether the NQTL is compliant with Federal parity requirements.[43] This attestation must be based on an analysis of these additional NQTLs that the State has evaluated. CMS may request additional information related to such additional NQTLs, as is necessary to monitor compliance.

The State must complete the Intro NQTL worksheets before it completes the NQTL comparative analyses for the five highlighted NQTLs in the NQTL worksheets ("N_NQTL-MCO," "T_NQTL-CHIP," and "Z_NQTL-ABP"). It is critical that the State completes the Intro NQTL worksheets accurately and comprehensively. For the five highlighted NQTLs, the entries in the Intro-NQTL worksheets directly impact the organization of the subsequent NQTL worksheets. Properly completing the Intro NQTL worksheets supports the State in providing accurate and comprehensive NQTL comparative analyses and can significantly reduce the amount of data entry it must report in the NQTL worksheets.

For example, the Intro-NQTL worksheets require the State to indicate to which benefit classification(s) each of the five highlighted NQTLs apply. If a State indicates in the Intro-NQTL

[43] For a non-exhaustive, illustrative list of NQTLs, see 42 CFR § 438.910(d)(2), 42 CFR § 457.496(d)(4)(ii), and 42 CFR § 440.395(b)(4)(ii) for MCO, CHIP, and ABP, respectively.

worksheets that prior authorization is not applied to emergency care within a benefit package (see Figure 17), then the corresponding prior authorization fields in the NQTL worksheets would turn gray and would not require data entry (see Figure 18).

Figure 17: Example Intro-NQTL Worksheet with Benefit Classification Selections

M. Nonquantitative Treatment Limitations (NQTLs) Information - MCO

This section relates to NQTLs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(d).

*Refer to Instructional Guide section 2.11 for more detail. For all benefit classifications, indicate **Yes** if the NQTL applies to benefits in the classification, Indicate **No** if the NQTL does not apply to benefits in the classification, or Indicate **N/A** if the entity providing benefits does not provide benefits in the classification.*

Step M-1: Highlighted NQTLs

Highlighted NQTLs are auto-populated	*Select from the pre-populated drop-down choices the entity providing MH, SUD, or both MH/SUD benefits. If MH and SUD benefits are provided by the same entity, then only the name of that entity will appear in the drop-down choices.*	*In each cell, please list the benefit packages to which the entity in Column E applies the respective NQTL in an identical manner. If the entity applies the NQTL in an identical manner to all benefit packages, indicate 'All'. If the entity applies the NQTL differently to different benefit packages, please create additional rows for each benefit package to which the entity applies the NQTL in a unique way.*	*Dropdown fiel*			
NQTL	**What entity provides MH and/or SUD benefits (i.e., State FFS, MCO, PIHP, PAHP)?**	**Benefit Package**	**Inpatient**	**Outpatient**	**Emergency Care**	**Prescription Drugs**
Prior Authorization	MCO A	All	Yes	Yes	No	Yes
Prior Authorization	MCO B	All	Yes	Yes	No	Yes
Prior Authorization	MCO C	All	Yes	Yes	No	Yes
Prior Authorization	MCO D	All	Yes	Yes	No	Yes

Figure 18: Example NQTL Worksheet Showing the Impact of Benefit Classification Selections from the Corresponding Intro-NQTL Worksheet

NQTL	Benefit Classificati	Entity and Benefit Package(	Comparability and Stringency Assessment Instr	Assessment Resul	Strategy Example: Treatment guidelines or gu
Prior Authorization	Emergency Care	All MCO A	**Comparability:** Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.		
Prior Authorization	Emergency Care	All MCO A	**Comparable but not identical**: If this option is chosen, explain (using the free text cells in Columns N-AC of this row, as applicable) how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL to MH/SUD benefits is comparable to the strategy, evidentiary standard, process, or other factor used in applying the NQTL to M/S benefits.		
Prior Authorization	Emergency Care	All MCO A	**Not Comparable**: If this option is chosen, describe the issue (using the free text cells in Columns N-AC of this row, as applicable) and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID number from the Issues for Discussion worksheet.		
Prior Authorization	Emergency Care	All MCO A	**Stringency:** Using the dropdown options in Columns N-AC of this row, assess the stringency with which the strategies, evidentiary standards, processes, or other factors used in applying the NQTL are applied to MH/SUD benefits compared to the stringency with which they are applied to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.		

In addition, as it is possible for States to have the same entity(ies) that provide(s) MH, SUD, and/or M/S benefits to Medicaid MCO, CHIP, and/or ABP benefit packages — and that this entity (or entities) applies the same NQTL(s) identically in the same benefit classifications, across program types — Column K allows the State to indicate if it has already provided the NQTL comparative analysis for a given entity on a worksheet for a different program type within

this Template. This avoids unnecessary duplication across Medicaid MCO, CHIP, and ABP benefit packages in the "N_NQTL-MCO," "T_NQTL-CHIP," and "Z_NQTL-ABP" worksheets.

2.11.2 Instructions

Regarding "Step-1: Highlighted NQTLs," the State should enter the following data for each highlighted NQTL that is applied to MH and/or SUD benefits into each of the columns in the table. If a State does not apply one or more of the highlighted NQTLs, no information is required.

- NQTL Column (Column D)
  - This field will be prepopulated, as the NQTLs listed are the five highlighted NQTLs.
- What entity provides MH and/or SUD benefits (i.e., State FFS, MCO, PIHP, PAHP)? Column (Column E)
  - The State should choose from the drop-down options of prepopulated entities that provide MH and/or SUD benefits.
  - The prepopulated entries are derived from the "C_MCO Program Type Data," "D_CHIP Program Type Data," and "E_ABP Program Type Data" worksheets, which include logic for distinguishing if a given entity provides both MH and SUD benefits, only MH benefits, or only SUD benefits.

As such, the prepopulated drop-down options will only indicate a distinction for "MH" or "SUD" if the entities that provide MH and SUD benefits are different.

    - If the entity(ies) that provide MH and SUD benefits are the same, there will be no additional distinction in the drop-down options.
    - If the State observes a data entry error (e.g., a missing entity that provides MH or SUD benefits), it should be fixed in Step 2 of the "C_MCO Program Type Data," "D_CHIP Program Type Data," and "E_ABP Program Type Data" worksheets.
  - The State should use different rows to select each entity that applies the respective NQTL.
- Benefit Package Column (Column F)
  - The State should enter the benefit package(s) in which the entity providing MH and/or SUD benefits (entered by the State in Column E) applies the NQTL.
  - Note that there are no drop-down options for the benefit package names. This enables the State to enter more than one benefit package that corresponds to the entity providing MH and/or SUD benefits (listed in Column E).
  - To determine which benefit packages to list in Benefit Package Column (Column F), the State should first consider if the entity listed in Column E applies the NQTL identically and for all the same benefit classifications across more than one benefit package within program type.

        - Note: If there are any differences in the way in which the entity applies the NQTL based on benefit package, or any differences in the benefit classifications in which the NQTL is applied, the State should enter information by benefit package using separate rows of data.
            - For example, MCO A applies Prior Authorization to the outpatient and prescription drugs benefit classifications identically across Benefit Package X and Benefit Package Y, but uses different clinical guidelines for Benefit Package Z. In this case, the State should select MCO A in two rows in Column E. In the first row, the State should enter "Benefit Package X, Benefit Package Y", and in the second row the State should enter "Benefit Package Z."
        - If there are no differences in the way in which the entity applies the NQTL based on benefit package, and no differences in the benefit classifications in which the NQTL is applied in all benefit packages, the State may enter "All" in Benefit Package Column (Column F) as it corresponds to the entity in Column E.
            - For example, a State has three benefit packages within a Medicaid MCO program type (Benefit Package X, Benefit Package Y, and Benefit Package Z), and MCO A provides MH/SUD and M/S benefits to all three benefit packages. MCO A applies Prior Authorization to the outpatient and prescription drugs benefit classifications identically across all benefit packages in the State, using the same policies and other documentation to apply the NQTL. In this case, the State should enter "All" in Benefit Package Column (Column F) for MCO A.
- Benefit Classifications Column (Columns G-J)
    - For each benefit classification, the State should choose from the following drop-down options:
        - Yes: If the NQTL applies to benefits in the classification
        - No: If the NQTL does not apply to benefits in the classification
        - N/A: If the entity providing benefits does not provide benefits in the classification.
    - The State should not leave the benefit classification options blank, as the drop-down options determine what is presented on the subsequent "N_NQTL-MCO," "T_NQTL-CHIP," and "Z_NQTL-ABP" worksheets.
- Column K: Has the State already entered its assessment of this entity's application of this NQTL in either the NQTL [MCO/CHIP/ABP] worksheet, and did the State find that the entity applies the NQTL in an identical manner as they do for this benefit package(s)?
    - As described above, a State may have MCO, CHIP, and/or ABP benefit packages that use the same entity(ies) to provide MH, SUD, and/or M/S benefits; it is also possible that the entity(ies) applies the same NQTL(s) identically in the same benefit classification(s).
    - The State should indicate "Yes" if the following conditions are met:

        - The entity provides MH, SUD, or both MH/SUD benefits in benefit packages that cover enrollees in more than one program type (MCO, CHIP, and/or ABP).
        - The entity either provides M/S benefits for those benefit packages, or the separate entity that provides M/S benefits is also the same for benefit packages in more than one program type.
        - For example, if MCO X delivers MH/SUD in both MCO and CHIP benefit packages, and in both instances MCO Y also delivers M/S.
        - The State has completed – in either the current or a prior version of the Template using the corresponding NQTL worksheet – an NQTL comparative analysis for the entity's application of the NQTL to a benefit package within another program type (i.e., Medicaid MCO, CHIP, or ABP).
        - The entity applies the NQTL to the benefit package(s) in the Benefit Package Column (Column F) identically to how it applies the NQTL as described in the NQTL worksheet for the other program type in which the entity operates (i.e., Medicaid MCO, CHIP, or ABP).
        - The entity applies the NQTL(s) in all the same benefit classifications across benefit packages.
    - For example, a State has one Medicaid MCO benefit package and one ABP benefit package operated by MCO A. ABP enrollees have mandatory enrollment in the Medicaid MCO, so MCO A provides MH, SUD, and M/S benefits across both the "MCO" and "ABP" benefit packages. MCO A applies prior authorization identically, and in the same benefit classifications, across the two benefit packages. The State is currently completing and submitting the Template as part of an ABP Parity Analysis. However, the State had previously completed and submitted the Template as part of a Medicaid MCO Parity analysis, that included the comparative analysis of MCO A's application of prior authorization, earlier in the year.
        - In this example, the State should select "Yes" in column K of the "Intro-NQTL-ABP" worksheet (see Figure 19), and all data fields corresponding to MCO B in the "NQTL-ABP" worksheet will turn gray and do not need to be completed (see Figure 20).
- If Yes, which worksheet can the NQTL assessment be found on? Column (Column L)
    - Rows in this column (Column L) default to gray unless the State selects "Yes" in Column K.
    - If the State answered, "Yes" to Column K, select from the drop-down options in this column (Column L) in which worksheet ("NQTL-MCO," "NQTL-CHIP," and "NQTL-ABP") the NQTL comparative analysis has been completed.
        - For example, using the example of MCO A above, the State should select "NQTL-MCO" from the drop-down menu (see Figure 19).

Columns K-L are intended to avoid unnecessary duplication across MCO, CHIP, and ABP benefit packages in the "N_NQTL-MCO," "T_NQTL-CHIP," and "Z_NQTL-ABP" worksheets.

Figure 19: Example Intro NQTL-CHIP Worksheet Showing How to Indicate an NQTL Assessment Can be Found on the NQTL-MCO Worksheet

F G H I J K L M

ordance with 42 CFR § 457.496(d)(4).

if the NQTL applies to benefits in the classification,
providing benefits does not provide benefits in the classification.

Color Legend
Do not enter data!

In each cell, please list the benefit packages to which the entity in Column E applies the respective NQTL in an identical manner. If the entity applies the NQTL in an identical manner to all benefit packages, indicate 'All'. If the entity applies the NQTL differently to different benefit packages, please create additional rows for each benefit package to which the entity applies the NQTL in a unique way.

Dropdown fields. Do not enter data if the cell is grayed out

Benefit Package	Inpatient	Outpatient	Emergency Care	Prescription Drugs	Has the State entered its assessment of this entity's application of this NQTL in the NQTL-MCO or NQTL-ABP worksheet, and did the entity apply the NQTL identically as they do for this benefit package(s)? If No, complete the T_NQTL_CHIP worksheet.	If Yes, which worksheet can the NQTL assessment be found on?
All	Yes	Yes	No	Yes	Yes	NQTL-MCO
All	Yes	Yes	No	Yes	Yes	NQTL-ABP NQTL-MCO
All	Yes	Yes	No	Yes	No	
All	Yes	Yes	No	Yes	No	

Figure 20: Example NQTL-CHIP Worksheet Showing the Impact of Selecting that an Entity's NQTL Assessment Can be Found on Another Worksheet

D E F G H M N O

T. Detail Nonquantitative Treatment Limitations (NQTLs) - CHIP

This section relates to NQTLs applied to benefits delivered to beneficiaries of Separate CHIPs in accordance with 42 CFR § 457.496(d)(4). Refer to Instructional Guide section 2.12 for more detail. Belo
Based on the responses from "Intro NQTL" tab, this tab compiles 5 highlighted NQTLs, all benefit classifications, and all Benefit Package & Entity Providing Benefits information into one table for States
Scroll down to access each NQTL section or use filters to access the NQTL section. Note that there is an "other" column available for each NQTL assessment step (e.g., strategy, evidentiary standard
evidentiary standards, processes, and other factors beyond the prepopulated examples. Otherwise, leave "other" fields blank.

The Strategies below are only examples. They are not required in th entity's application of this NQTL, select 'Not Applicable'.

Prepopulated field	*Prepopulated field*	*Auto- Populated Field*	*Refer to Instructional Guide*			
CHIP NQTLs	**Benefit Classification**	**Entity and Benefit Package(s) Providing Benefits**	**Comparability and Stringency Assessment Instructions**	**Overall: assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organizations**	**Strategy Example: Rationales for threshold professional standards, a schedules**
Prior Authorization	Inpatient	All MCO A	**Comparability:** Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.			
Prior Authorization	Inpatient	All MCO A	**Comparable but not identical**: If this option is chosen, explain (using the free text cells in Columns N-AC of this row, as applicable) how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL to MH/SUD benefits is comparable to the strategy, evidentiary standard, process, or other factor used in applying the NQTL to M/S benefits.			
Prior Authorization	Inpatient	All MCO A	**Not Comparable**: If this option is chosen, describe the issue (using the free text cells in Columns N-AC of this row, as applicable) and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID number from the Issues for Discussion			

Accurately completing the final two columns of "Step 1: Highlighted NQTLs" (Columns K-L, as shown in Figure 19) in the Intro-NQTL worksheet is critical to minimize the State's data entry, while also ensuring CMS can find the necessary information to complete its review.

Regarding "Step-2: Other NQTLs," the State should list each additional NQTL applied to MH and/or SUD benefits by entities providing benefits in the State. In Column D, States should indicate the name and a brief description of the NQTL in the fields next to "Other NQTL 1," "Other NQTL 2," etc. Columns E-J ask the State to provide the same information regarding the NQTL, entity providing benefits, benefit package, and applicable benefit classifications as required by "Step 1: Highlighted NQTLs." The only difference is that the NQTL Column (Column D) is not pre-populated in this table.

Figure 21: Example "Other NQTLs" Table Retrospective Review Entered by the State

A B C D E F G H I J K

Step S-2: Other NQTLs

NQTL *(If applicable, enter the name of and briefly describe each additional NQTL that is applied to benefits after "Other NQTL 1," "Other NQTL 2," etc.)*	What entity provides MH and/or SUD benefits (i.e., State FFS, MCO, PIHP, PAHP)?	Benefit Package	Inpatient	Outpatient	Emergency Care	Prescription Drugs	Has the State determined that the NQTL is designed and applied comparably and no more stringently to MH/SUD benefits than it is designed and applied to M/S benefits? If No, describe any issues in the U_Issues for Discussion-CHIP worksheet
Other NQTL 1: Retrospective Review. This NQTL is applied after treatment has been provided for MH/SUD and M/S services.	MCO A	All	Yes	Yes	Yes	Yes	Yes
	MCO B	All	Yes	Yes	Yes	Yes	Yes
	MCO C	All	Yes	Yes	Yes	Yes	Yes
	MCO D	All	Yes	Yes	Yes	Yes	Yes

The second table does not include the same columns as required in "Step 1: Highlighted NQTLs." This is because a detailed analysis for these additional NQTLs is not required to be entered in the "N_NQTL-MCO," "T_NQTL-CHIP," and "Z_NQTL-ABP" worksheets in this template.

Column K in the second table asks the State the following: "Has the State determined that the NQTL is applied comparably and no more stringently to MH/SUD benefits than it is applied to M/S benefits?" The State should select "Yes" or "No" from the drop-down options to provide this attestation of compliance for each additional NQTL entered by the State. If the State selects "No," it should describe identified issues in the appropriate "Issues for Discussion" worksheet. If the State selects "Yes," no additional information on the associated NQTL is required to be entered in the Template. However, as noted, CMS may request additional information related to these NQTLs, as necessary to monitor compliance.

2.12 Nonquantitative Treatment Limitations (Medicaid MCO, CHIP, ABP)

2.12.1 Regulatory basis for the worksheets

Medicaid MCO: 42 CFR § 438.910(d)

CHIP: 42 CFR § 457.496(d)(4)

ABP: 42 CFR § 440.395(b)(4)

2.12.2 Overall Layout

The instructions and layout for the "N_NQTL-MCO," "T_NQTL-CHIP," and "Z_NQTL-ABP" worksheets are the same. On these worksheets, the State documents its assessment of the comparability and stringency with which the entity(ies) providing benefits design and apply the five highlighted NQTLs to MH/SUD benefits.

According to Federal parity requirements, an NQTL cannot be imposed on MH/SUD benefits unless, as written and in operation, the strategies, evidentiary standards, processes, and other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the strategies, evidentiary standards, processes, and other factors used in applying the NQTL to M/S benefits.[44] Within this Template, the terms "comparability assessment" and "stringency assessment" describe the assessment of those strategies, evidentiary standards, processes, and/or other factors used in the design and application of NQTLs to MH/SUD benefits compared with their use in the design and application of M/S benefits.

States should document their comparability and stringency assessments for the five prepopulated highlighted NQTLs within the Template. States should document their assessments for each entity delivering benefits for MH, SUD, or both; for each of the benefit packages that the State offers within the respective program types (i.e., Medicaid MCO, CHIP, and/or ABP); and within each of the four benefit classifications in which the entity applies the respective NQTL.

The NQTL Column (Column E) and Benefit Classification Column (Column F) columns are prepopulated.

The Entity and Benefit Package(s) Providing Benefits Column (Column G) column shows the specific entity and the benefit package(s) that is under assessment by the State. This column is auto-populated with the entities and benefit packages entered by the State in the Intro-NQTL worksheet. See Figure 22 for an example of the prepopulated Entity and Benefit Package(s) Providing Benefits Column (Column G).

[44] 42 CFR § 438.910(d)(1), 42 CFR § 457.496(d)(4)(i), and 42 CFR § 440.395(b)(4)(i) for MCO, CHIP, and ABP, respectively.

Figure 22: Example NQTL Worksheet Showing Auto-populated Entities/Benefit Packages

A D E F G H M

N. Detail Nonquantitative Treatment Limitations (NQTLs) - MCO

This section relates to NQTLs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(d). Refer to Instructional
Based on the responses from "Intro NQTL" tab, this tab compiles 5 highlighted NQTLs, all benefit classifications, and all Benefit Package & Entity Providing
Scroll down to access each NQTL section or use filters to access the NQTL section. Note that there is an "other" column available for each NQTL assessr
evidentiary standards, processes, and other factors beyond the prepopulated examples. Otherwise, leave "other" fields blank.

Prepopulated field	*Prepopulated field*	*Auto- Populated Field*	*Refer to Instructional Guide*		***The Strategi entity's appli***
NQTL	**Benefit Classification**	**Entity and Benefit Package(s) Providing Benefits**	**Comparability and Stringency Assessment Instructions**	**Assessment Result**	**Strategy Exa Treatment gu guidelines p party organiz**
Prior Authorization	Inpatient	All MCO A	**Comparability:** Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.		
Prior Authorization	Inpatient	All MCO A	**Comparable but not identical**: If this option is chosen, explain (using the free text cells in Columns N-AC of this row, as applicable) how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL to MH/SUD benefits is comparable to the strategy, evidentiary standard, process, or other factor used in applying the NQTL to M/S benefits.		
Prior Authorization	Inpatient	All MCO A	**Not Comparable**: If this option is chosen, describe the issue (using the free text cells in Columns N-AC of this row, as applicable) and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID number from the Issues for Discussion worksheet.		

This worksheet contains a significant number of rows, not all of which will likely be used. For example, certain NQTLs or benefit classifications within an NQTL may not be applicable. To navigate to specific NQTLs, benefit classifications, and/or Entity and Benefit Package combinations, use the filters in the header row as shown in Figure 23. This will allow for more efficient data entry and review.

Figure 23: Example of How to "Filter" NQTL Worksheet

N. Detail Nonquantitative Treatment Limitations (NQTLs) - MCO

This section relates to NQTLs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.9
Based on the responses from "Intro NQTL" tab, this tab compiles 5 highlighted NQTLs, all benefit classifications, and all Benefi
Scroll down to access each NQTL section or use filters to access the NQTL section. Note that there is an "other" column avail
evidentiary standards, processes, and other factors beyond the prepopulated examples. Otherwise, leave "other" fields blank.

Prepopulated field	*Prepopulated field*	*Auto- Populated Field*	*Refer to Instructional Guide*
NQTL	**Benefit Classification**	**Entity and Benefit Package(s) Providing Benefits**	**Comparability and Stringency Assessment Instructions**
Prior		All MCO A	**Comparability:** Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.
Prior		All MCO A	**Comparable but not identical**: If this option is chosen, explain (using the free text cells in Columns N-AC of this row, as applicable) how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL to MH/SUD benefits is comparable to the strategy, evidentiary standard, process, or other factor used in applying the NQTL to M/S benefits.
Prior		All MCO A	**Not Comparable**: If this option is chosen, describe the issue (using the free text cells in Columns N-AC of this row, as applicable) and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID

Sort A to Z
Sort Z to A
Sort by Color
Sheet View
Clear Filter From "Benefit Classific..."
Filter by Color
Text Filters
Search
(Select All)
Emergency Care
Inpatient
Outpatient
Prescription Drug
OK
Cancel

The Comparability and Stringency Assessments Column (Column H) contains prepopulated language that provides instruction related to the corresponding data fields in the same rows across Columns N-AC.

As noted, fields for each benefit classification are prepopulated. However, if a State indicates in one of the Intro-NQTL worksheets that an entity does not apply a certain NQTL within a particular benefit classification (e.g., emergency care, as shown in Figure 24) within a particular benefit package, the corresponding data fields in Columns N-AC in the corresponding NQTL worksheet will "gray out," and no entries are needed as shown in Figure 25.

Figure 24: Example Intro-NQTL Worksheet with Benefit Classification Selections

M. Nonquantitative Treatment Limitations (NQTLs) Information - MCO

This section relates to NQTLs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(d).

*Refer to Instructional Guide section 2.11 for more detail. For all benefit classifications, indicate **Yes** if the NQTL applies to benefits in the classification,*
*Indicate **No** if the NQTL does not apply to benefits in the classification, or Indicate **N/A** if the entity providing benefits does not provide benefits in the classification.*

Step M-1: Highlighted NQTLs

Highlighted NQTLs are auto-populated	*Select from the pre-populated drop-down choices the entity providing MH, SUD, or both MH/SUD benefits. If MH and SUD benefits are provided by the same entity, then only the name of that entity will appear in the drop-down choices.*	*In each cell, please list the benefit packages to which the entity in Column E applies the respective NQTL in an identical manner. If the entity applies the NQTL in an identical manner to all benefit packages, indicate 'All'. If the entity applies the NQTL differently to different benefit packages, please create additional rows for each benefit package to which the entity applies the NQTL in a unique way.*	*Dropdown fiel*			
NQTL	**What entity provides MH and/or SUD benefits (i.e., State FFS, MCO, PIHP, PAHP)?**	**Benefit Package**	**Inpatient**	**Outpatient**	**Emergency Care**	**Prescription Drugs**
Prior Authorization	MCO A	All	Yes	Yes	No	Yes
Prior Authorization	MCO B	All	Yes	Yes	No	Yes
Prior Authorization	MCO C	All	Yes	Yes	No	Yes
Prior Authorization	MCO D	All	Yes	Yes	No	Yes

Figure 25:26 Example NQTL Worksheet Demonstrating the Impact of the Benefit Classification Selections in the Corresponding Intro-NQTL Worksheet

NQTL	Benefit Classificati	Entity and Benefit Package(	Comparability and Stringency Assessment Instr	Assessment Resul	Strategy Example: Treatment guidelines or gu
Prior Authorization	Emergency Care	All MCO A	**Comparability:** Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.		
Prior Authorization	Emergency Care	All MCO A	**Comparable but not identical**: If this option is chosen, explain (using the free text cells in Columns N-AC of this row, as applicable) how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL to MH/SUD benefits is comparable to the strategy, evidentiary standard, process, or other factor used in applying the NQTL to M/S benefits.		
Prior Authorization	Emergency Care	All MCO A	**Not Comparable**: If this option is chosen, describe the issue (using the free text cells in Columns N-AC of this row, as applicable) and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID number from the Issues for Discussion worksheet.		
Prior Authorization	Emergency Care	All MCO A	**Stringency:** Using the dropdown options in Columns N-AC of this row, assess the stringency with which the strategies, evidentiary standards, processes, or other factors used in applying the NQTL are applied to MH/SUD benefits compared to the stringency with which they are applied to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.		

2.12.3 Instructions

States should assess the comparability and stringency for each of the strategies, evidentiary standards, processes, and other factors[45] that the entity employs when designing and applying each of the five highlighted NQTLs. The State should assess comparability and stringency by

[45] 42 CFR § 438.910(d)(1), 42 CFR § 457.496(d)(4)(i), and 42 CFR § 440.395(b)(4)(i) for MCO, CHIP, and ABP, respectively.

comparing information from the entity(ies) that provides MH and/or SUD benefits with information from the entity(ies) that provides M/S benefits. The results should be documented in this Template.

To improve consistency and reduce administrative burden, the Template includes prepopulated examples of categories or types strategies, evidentiary standards, and processes (see Figure 26).

The prepopulated strategies, evidentiary standards, and processes are only examples; there is no requirement that they be used in the design or the application of an NQTL.

If any of the strategies, evidentiary standards, and/or processes listed were not used in designing or applying the NQTL, the State can mark "Not applicable."

Figure 27: Example of Types of Strategies in the NQTL Worksheet

H	M	N	O
MCO			
id MCOs in accordance with 42 CFR § 438.910(d). Refer to Instructional Guide section 2.12 for more detail. Below information is a summ			
QTLs, all benefit classifications, and all Benefit Package & Entity Providing Benefits information into one table for States' parity documenta			
ion. Note that there is an "other" column available for each NQTL assessment step (e.g., strategy, evidentiary standards) to allow States t			
mples. Otherwise, leave "other" fields blank.			
Refer to Instructional Guide		***The Strategies below are only examples. They are not required in the ap entity's application of this NQTL, select 'Not Applicable'.***	
Comparability and Stringency Assessment Instructions	**Assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organizations**	**Strategy Example: Rationales for threshold amounts, professional standards, and fee schedules**
Comparability: Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.			

There are "Other" columns throughout the worksheet where the State should add any other strategies, evidentiary standards, and processes that were used in the design or application of the NQTL and that were not included in the prepopulated examples. See Appendix for a listing of examples of strategies, evidentiary standards, and processes. To add an 'Other' strategy, evidentiary standard, process, or other factor, type the category directly into the 'Other' field in the header row (see Figure 27).

Figure 28:29 Example of "Other" Column for Type of Strategy in the NQTL Worksheet

H	M	N	O	P	Q	R
MCO					**Color Legend:**	
id MCOs in accordance with 42 CFR § 438.910(d). Refer to Instructional Guide section 2.12 for more detail. Below information is a summary.					Data entry field	
QTLs, all benefit classifications, and all Benefit Package & Entity Providing Benefits information into one table for States' parity documentation and					Do not type in data in these fields	
ion. Note that there is an "other" column available for each NQTL assessment step (e.g., strategy, evidentiary standards) to allow States to enter any other strategies,						
mples. Otherwise, leave "other" fields blank.						
Refer to Instructional Guide		***The Strategies below are only examples. They are not required in the application NQTLs. Please see column H for instructions. If the Strategy does not***				*Type next to "Other: " to add a new type.*
		entity's application of this NQTL, select 'Not Applicable'.				
Comparability and Stringency Assessment Instructions	**Assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organizations**	**Strategy Example: Rationales for threshold amounts, professional standards, and fee schedules**	**Strategy Example: Breadth of sources and evidence considered**	**Strategy Example: Consultations with panels of experts in designing the NQTL**	**Strategy Other:**
Comparability: Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.						

There are also columns for "Other Factors" if the State uses any other factors (beyond the strategies, evidentiary standards, and processes entered) in the design or application of NQTLs. Those "Other Factors" can be listed using columns AA-AC.

The State should complete an assessment of the comparability and stringency with which each of these strategies, evidentiary standards, processes, and/or other factors are applied and used in the design of NQTLs to demonstrate compliance with Federal parity requirements. The "Comparability Assessment" and "Stringency Assessment" are described below. There is a final field below these assessments in which the State provides an overall "Assessment Result," also described below.

Comparability Assessment

For each prepopulated or State-entered example (or category) of a strategy, evidentiary standard, process, and other factor, the State should first select from the four drop-down options in the Assessment row that begins "Comparability: Using the drop-down options in Columns N-AC…" (see Figure 28) to select the result of their assessment. The four drop-down options, explained in detail below, are as follows:

- Identical therefore Comparable
- Comparable but Not Identical
- Not Comparable
- Not Applicable

Figure 308: Example NQTL Worksheet Showing Comparability Assessment Drop-down Options

G H M N

mitations (NQTLs) - MCO

ered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(d). Refer to Instructional Guide section 2.12 for more det
b compiles 5 highlighted NQTLs, all benefit classifications, and all Benefit Package & Entity Providing Benefits information into one ta
s to access the NQTL section. Note that there is an "other" column available for each NQTL assessment step (e.g., strategy, evider
eyond the prepopulated examples. Otherwise, leave "other" fields blank.

The Strategies below are only examples. T
entity's application of this NQTL, select 'N

Auto- Populated Field	*Refer to Instructional Guide*			
Entity and Benefit Package(s) Providing Benefits	**Comparability and Stringency Assessment Instructions**	**Assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organizations**	**Str Ra pro sc**
All MCO A	**Comparability:** Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.			
All MCO A	**Comparable but not identical**: If this option is chosen, explain (using the free text cells in Columns N-AC of this row, as applicable) how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL to MH/SUD benefits is comparable to the strategy, evidentiary standard, process, or other factor used in applying the NQTL to M/S benefits.			

Identical therefore comparable
Comparable but not identical
Not comparable
Not applicable

The State's selection from the drop-down options determines what the State should do next. Instructions based on a selection of each drop-down options are provided below:

Identical therefore Comparable: If the State selects this option, no further action or explanation is necessary to demonstrate the comparability of the application of the NQTL for that category of strategy, evidentiary standard, process, or other factor.

The Template contains conditional formatting so that if this option is selected, the cells for "Comparable but not identical" and "Not Comparable" for that specific category of strategy, evidentiary standard, process, or other factor will turn gray.

> IMPORTANT: By selecting "Identical therefore Comparable," the State is attesting that the category of a strategy, evidentiary standard, process, or other factor is identical in both writing and operation in its application to both MH/SUD and M/S benefits.

If there are even slight differences in how the category of strategy, evidentiary standard, process, or other factor is applied to MH/SUD benefits compared to M/S benefits, then

the State should select "Comparable but Not Identical" or "Not Comparable," as applicable.

> For example, if MCO A uses InterQual criteria as the objective third-party standard to apply utilization management NQTLs to both MH/SUD and M/S benefits, the State should select "Identical and Comparable"; if MCO A uses InterQual criteria for M/S benefits, but a separate, but still objective third-party standard for MH/SUD benefits, the State should select "Comparable but Not Identical" and follow the instructions below.

Comparable but Not Identical: If the design and application of the category of strategy, evidentiary standard, process, or other factor is not identical across MH/SUD benefits and M/S benefits, then the State is required to provide a sufficient explanation of how and why it made its determination that the entity's application of the category is comparable. A sufficient explanation should address at least the following four items:

1. How the category's application to MH/SUD benefits differs from its application to M/S benefits.
2. The reason(s) why the category's application is different for MH/SUD and M/S benefits.
3. The reason why the State determined that the entity's application of the category to MH/SUD benefits is comparable to its application of the category to M/S benefits, notwithstanding the difference.
4. An explanation of how the differences in the application of the limitations do not adversely affect access to MH/SUD benefits.

The following example demonstrates a sufficient explanation if "Comparable but Not Identical" was selected for a category of a process – "procedures to submit information" for Prior Authorization. Note that the following is an illustrative example only.

> Based on the managed care plan's policy, the method to submit information to authorize coverage for an M/S or MH/SUD item or service differs because the MH/SUD submission can be done via a phone or fax, while M/S prior authorization submissions are via fax only. The reason why this process applied to M/S and MH/SUD benefits differs is that, based on managed care plan experience, some MH/SUD providers cannot readily access fax machines and may require prompt resolutions (such as by phone) regarding coverage of MH/SUD benefits during a beneficiary crisis. The reason why this process is comparable notwithstanding the difference is that the method of submitting information allows for an additional method (i.e., phone) for MH/SUD benefits compared to M/S benefits. Because there is an additional method to submit information for MH/SUD benefits, the differences do not adversely affect access to MH/SUD benefits.

The Template contains conditional formatting so that if "Comparable but Not Identical" is selected, the cell for "Not Comparable" for that specific category of strategy, evidentiary standard, process, or other factor will turn gray and no data entry is needed.

Not Comparable: If the State selects "Not Comparable," it should describe the issue and then record the details in the Issues for Discussion worksheets ("O_Issues for Discussion-MCO,"

"U_Issues for Discussion-CHIP," "AA_Issues for Discussion-ABP") described later in this Guide. Once the State has entered the details in the applicable Issues for Discussion worksheet, the State should record the corresponding ID number from the Issues for Discussion worksheet in the applicable NQTL worksheet field (see Figure 29). The Template contains conditional formatting so that if this option is selected, the cell for "Comparable but not identical" for that specific category of strategy, evidentiary standard, process, or other factor will turn gray and no data entry is needed.

Figure 31:32 Example NQTL Worksheet with an Assessment of "Not Comparable"

G H M N

mitations (NQTLs) - MCO

ered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(d). Refer to Instructional Guide section 2.12 for mo
b compiles 5 highlighted NQTLs, all benefit classifications, and all Benefit Package & Entity Providing Benefits information into
s to access the NQTL section. Note that there is an "other" column available for each NQTL assessment step (e.g., strategy,
eyond the prepopulated examples. Otherwise, leave "other" fields blank.

Auto- Populated Field	*Refer to Instructional Guide*		***The Strategies below are only exam entity's application of this NQTL, sel***
Entity and Benefit Package(s) Providing Benefits	**Comparability and Stringency Assessment Instructions**	**Assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organizations**
All MCO A	**Comparability:** Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.		Not comparable
All MCO A	**Comparable but not identical**: If this option is chosen, explain (using the free text cells in Columns N-AC of this row, as applicable) how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL to MH/SUD benefits is comparable to the strategy, evidentiary standard, process, or other factor used in applying the NQTL to M/S benefits.		
All MCO A	**Not Comparable**: If this option is chosen, describe the issue (using the free text cells in Columns N-AC of this row, as applicable) and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID number from the Issues for Discussion worksheet.		MCO A uses plan-developed treatment guidelines for MH/SUD, but uses InterQual for M/S benefits. ID Number O-1.

The following example from the CMS Parity Toolkit demonstrates what would be considered "Not Comparable." Note that the following is an illustrative example only.

- PIHP A's written policies and procedures state that MCO enrollees cannot obtain inpatient, out-of-state treatment for eating disorders unless there is no in-state bed available. Consistent with recommendations for family involvement in a national practice guideline, this limit was established to facilitate ongoing family involvement by minimizing travel distances. MCO Z's policies and procedures do not include limits on out-of-state treatment for M/S conditions despite comparable national practice guidelines calling for family involvement. The NQTL (i.e., coverage limits on out-of-state inpatient treatment when an in-state bed is available) is impermissible because the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to MH/SUD benefits (e.g., in policies and procedures) are not comparable.[46]

Not Applicable: If the State selects that a category of strategy, evidentiary standard, process, or other factor is "Not Applicable," no further action is needed for that category.

The Template contains conditional formatting so that if "Not Applicable" is selected, the cells for "Comparable but Not Identical" and "Not Comparable" for that specific category of strategy, evidentiary standard, process, or other factor will turn gray, and no data entry is needed.

Stringency Assessment

For each prepopulated or State-entered example of a strategy, evidentiary standard, process, and other factor, the State should first select from the four drop-down options in the Assessment row that begins "Stringency: Using the drop-down options in Columns N-AC…" (see Figure XX) to select the result of their assessment. The four drop-down options, explained in detail below, are as follows:

- Identical therefore No More Stringent
- No More Stringent but Not Identical
- More Stringent
- Not Applicable

The State's selection from the drop-down options determines what the State should do next. Instructions based on a selection of each drop-down options are provided below:

Identical therefore No More Stringent: If the State selects this option, no further action or explanation is necessary to demonstrate the stringency with which the NQTL is applied for that category of strategy, evidentiary standard, process, or other factor.

[46] See Section 6.3, p. 35 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

The Template contains conditional formatting so that if this option is selected, the cells for "No More Stringent but Not Identical" and "More Stringent" for that specific category of strategy, evidentiary standard, process, or other factor will turn gray.

> **IMPORTANT:** By selecting "Identical therefore No More Stringent," the State is attesting that the category of strategy, evidentiary standard, process, or other factor is identical in both writing and operation in its application to both MH/SUD and M/S benefits.

If there are even slight differences in how the category of strategy, evidentiary standard, process, or other factor is applied to MH/SUD benefits compared to M/S benefits, then the State should select "No More Stringent but not Identical" or "More Stringent," as applicable.

No More Stringent but Not Identical: If the design and application of the category of strategy, evidentiary standard, process, or other factor is not identical across MH/SUD benefits and M/S benefits, then the State is required to provide a sufficient explanation of how and why it made its determination that the entity's application of the category is no more stringently applied to MH/SUD benefits. A sufficient explanation should address at least the following four items:

1. How the category's application to MH/SUD benefits differs from its application to M/S benefits.
2. The reason(s) why the category's application is different for MH/SUD and M/S benefits.
3. The reason why the State determined that the entity's application of the category to MH/SUD benefits is no more stringent to its application of the category to M/S benefits, notwithstanding the difference.
4. An explanation of how the differences in the application of the limitations do not adversely affect access to MH/SUD benefits.

The following example demonstrates a sufficient explanation if "No More Stringent but Not Identical" was selected for a category of a strategy – "rationale for threshold amounts" for Standards for Access to Out-of-Network Care. Note that the following is an illustrative example only.

> To minimize excessive out-of-network utilization, while maintaining access to care, a managed care plan's policy states that, for MH/SUD and M/S services alike, beneficiaries can seek care from out-of-network providers if their appointment wait time (i.e., threshold) to see an in-network provider exceeds 30 days. However, in practice, the policy differs because the plan allows beneficiaries to obtain MH/SUD services from out-of-network providers when their appointment wait time to see a provider in-network exceeds only 14 days. The plan does not allow a similar exception for any M/S services. The reason for this difference is that there is a shortage of in-network MH/SUD providers, and there is a heightened risk of overdose, relapse, and other acute care needs if MH/SUD services are delayed. The reason why this strategy is not more stringent notwithstanding the difference is that the plan's exception makes it easier for

beneficiaries to obtain out-of-network MH/SUD services when compared to obtaining similar M/S services. For this same reason, the difference does not adversely affect access to MH/SUD services.

The Template contains conditional formatting so that if "No More Stringent but Not Identical" is selected, the cell for "More Stringent" for that specific category of strategy, evidentiary standard, process, or other factor will turn gray and no data entry is needed (see Figure 30).

Figure 33: Example NQTL Worksheet with an Assessment of "Not More Stringent but Not Identical"

D	NQTL	Benefit Classificati	Entity and Benefit Packa	Comparability and Stringency Assessment In	Assessment	Strategy Example: Treatment guidelines	Strategy Example: Rationales for threshold amounts, profession
				of this row, as applicable), report the corresponding ID number from the Issues for Discussion worksheet.			
	Prior Authorization	Inpatient	All MCO A	**Stringency:** Using the dropdown options in Columns N-AC of this row, assess the stringency with which the strategies, evidentiary standards, processes, or other factors used in applying the NQTL are applied to MH/SUD benefits compared to the stringency with which they are applied to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.			No more stringent but not identical
	Prior Authorization	Inpatient	All MCO A	**No more stringent but not identical:** If this option is chosen (using the free text cells in Columns N-AC of this row, as applicable), explain how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL is applied no more stringently to MH/SUD benefits than it is applied to M/S benefits.			To minimize excessive out-of-network utilization, while maintaining access to care, a managed care plan's policy states that, for MH/SUD and M/S services alike, beneficiaries can seek care from out-of-network providers if their appointment wait time (i.e., threshold) to see an in-network provider exceeds 30 days. However, in practice, the policy differs because the plan allows beneficiaries to obtain MH/SUD services from out-of-network providers when their appointment wait time to see a provider in-network exceeds only 14 days. The plan does not allow a similar exception for any M/S services. The reason for this difference is that there is a shortage of in-network MH/SUD providers, and there is a heightened risk of overdose, relapse, and other acute care needs if MH/SUD services are delayed. The reason why this strategy is not more stringent notwithstanding the difference is that the plan's exception makes it easier for beneficiaries to obtain out-of-network MH/SUD services when compared to obtaining similar M/S services. For this same reason, the difference does not adversely affect access to MH/SUD services.
	Prior Authorization	Inpatient	All MCO A	**More Stringent:** If this option is chosen, describe the issue (using the free text cells in Columns N-AC of this row, as applicable) and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID number from the Issues for Discussion worksheet			

<u>More Stringent</u>: If the State selects "More Stringent," it should describe the issue and then record the details in the Issues for Discussion worksheets ("O_Issues for Discussion-MCO," "U_Issues for Discussion-CHIP," "AA_Issues for Discussion-ABP") described later in this Guide. Once the State has entered the details in the applicable Issues for Discussion worksheet, the State should record the corresponding ID number from the Issues for Discussion worksheet in the applicable NQTL worksheet field. The Template contains conditional formatting so that if this option is selected, the cell for "No More Stringent but Not Identical" for that specific category of strategy, evidentiary standard, process, or other factor will turn gray and no data entry is needed.

The following example from the CMS Parity Toolkit demonstrates what would be considered "More Stringent." Note that the following is an illustrative example only.

- Both PIHP A's and MCO Z's written policies and procedures exclude coverage of out-of-state inpatient treatment unless no in-state bed is available. But in operation, MCO Z

makes exceptions to this exclusion for certain M/S conditions when an out-of-state facility is certified as a "center of excellence." PIHP A does not make any exceptions to the policy. The NQTL is impermissible because it is more stringently applied to coverage for treatment of MH/SUD conditions (i.e., there are no exceptions to the operating policy and procedure for MH/SUD conditions) than it is to coverage for treatment of M/S conditions.[47]

Not Applicable: If the State selects that a category of strategy, evidentiary standard, process, or other factor is "Not Applicable," no further action is needed for that category.

The Template contains conditional formatting so that if "Not Applicable" is selected, the cells for "No More Stringent but Not Identical" and "More Stringent" for that specific category of strategy, evidentiary standard, process, or other factor will turn gray, and no data entry is needed.

Assessment Result

Lastly, the State should indicate an assessment result by selecting a drop-down option ("Met" or "Not Met") in the Assessment Result Column (Column M) for every applicable combination of Entity and Benefit Package (see Figure 31), in every benefit classification for every NQTL.

- If the State has selected either "Not Comparable" or "More Stringent" for any category of strategy, evidentiary standard, process, or other factor, then the State should select "Not Met" for that specified Entity/Benefit Package, within the specified benefit classification and NQTL
- If neither "Not Comparable" nor "More Stringent" were ever selected, then the State should select "Met."

The Assessment Result Column only includes a single drop-down selection for each benefit classification in each entity/benefit package combination within the analysis. All other cells in the column do not allow data entry.

[47] See Section 6.3, p. 35 of *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (January 17, 2017), located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

Figure 34:35 Example NQTL Worksheet Showing the "Assessment Result" Field

Benefit Classificati	Entity and Benefit Package(	Comparability and Stringency Assessment Instr	Assessment Result	Strategy Example: Treatment g
Inpatient	All MCO A	and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID number from the Issues for Discussion worksheet.		
Inpatient	All MCO A	**Stringency:** Using the dropdown options in Columns N-AC of this row, assess the stringency with which the strategies, evidentiary standards, processes, or other factors used in applying the NQTL are applied to MH/SUD benefits compared to the stringency with which they are applied to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.		Identical therefore no more stringent
Inpatient	All MCO A	**No more stringent but not identical:** If this option is chosen (using the free text cells in Columns N-AC of this row, as applicable), explain how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL is applied no more stringently to MH/SUD benefits than it is applied to M/S benefits.		
Inpatient	All MCO A	**More Stringent:** If this option is chosen, describe the issue (using the free text cells in Columns N-AC of this row, as applicable) and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID number from the Issues for Discussion worksheet		
Inpatient	All MCO A	**Assessment Result:** Choose one answer for the plan's benefit classification & criteria	Met Not Met	
		Comparability: Using the dropdown options in Columns N-AC of this row, assess the		

2.13 Issues for Discussion (Medicaid MCO, CHIP, ABP)

2.13.1 Overall Layout

The instructions for the "O_Issues for Discussion-MCO," "U_Issues for Discussion-CHIP," and "AA_Issues for Discussion-ABP" worksheets are the same. Each Issues for Discussion worksheet summarizes the State's identified issues that may require discussion across all other completed worksheets for that program type.

IMPORTANT: In the Issues for Discussion worksheet:

- The State cannot delete rows. Resolved issues for discussion will remain in the worksheet, with the "Issue Resolved-ACTUAL Date" identified.
- The State can edit existing or enter new data in the cells.
- ID Numbers will not be repeated (even when previous issues are resolved). Each new issue is assigned a new ID Number.

2.13.2 Instructions

The following describes the steps a State should take in filling out the Issues for Discussion worksheets under three scenarios: New Entry, Update Existing Entry, and No Changes.

Scenario 1: New Entry

Step 1: The State identifies a new issue for discussion. The State should navigate to the Issues for Discussion worksheet specific to MCO, CHIP, or ABP and complete the following fields:

- ID Number Column (Column A)
  - This field is prepopulated. No action from the State is necessary.
- Entry Type Column (Column B)
  - The State should select "New" from the drop-down options to indicate "New" if this is a new issue for discussion that has not been identified in a prior submission.
- Relevant Benefit Package(s) Column (Column C)
  - The State should indicate the relevant benefit package(s) to which this issue for discussion applies.
- Relevant Template Section Column (Column D)
  - The State should select from the drop-down options to indicate the relevant Template section.
- Relevant Entity (or Entities) Providing Benefits Column (Column E)
  - The State should indicate the name of the relevant entity (or entities) to which this issue for discussion applies.
- Relevant Benefit Classification(s) Column (Column F)
  - The State should select from the drop-down options to indicate the relevant benefit classification to which this issue for discussion applies. The drop-down options only enable the State to select a single benefit classification. If an issue impacts multiple benefit classifications, the State should enter an additional issue for discussion in a subsequent row.
- Description of Issue for Discussion Column (Column G)
  - The State should provide a description of the issue for discussion, including the current date, in the format MM/DD/YYYY, prior to the free text.
- Does the Issue for Discussion relate to Operations, Documentation, or Both? Column (Column H)
  - The State should select one of the following drop-down options:
    - **Operations:** If the issue for discussion is still operationally in effect, impacting enrollees and/or providers.
    - **Documentation:** If the issue for discussion has been resolved operationally, but the formal policy or other documentation has not yet been updated accordingly.
    - **Both:** If the issue for discussion is related to both operations and documentation.
- Description of Past and/or Future Action(s) to Address the Issue for Discussion Column (Column I)
  - The State should provide a description of past and/or future action(s) addressing the issue for discussion, including interactions with managed care plans, CMS,

other involved stakeholders, and any State laws, regulations, or policies that require a change. When making entries to this field, the State should include a date (MM/DD/YYYY) prior to the free text.

- Issue Resolved - EXPECTED Date Column (Column J)
  - The State should provide the date it expects the concern to be resolved, in the format MM/DD/YYYY.
- Issue Resolved - ACTUAL Date Column (Column K)
  - The State should provide the actual date the issue was resolved, in the format MM/DD/YYYY. If the issue is not yet resolved, the State should leave this field blank.

Figure 32 below provides an example of a new issue for discussion entry.

Figure 36: Example of a "New" Issue for Discussion Entry

O. Issues for Discussion - MCO

Refer to Instructional Guide section 2.13 for more detail.

A	B	C	D	E	F	G	H	I	J	K
Auto-Populated									Date. Mm/dd/yyyy	Date. Mm/dd/yyyy
ID Number	Entry Type (New, Update, No changes)	Relevant Benefit Package(s)	Relevant Template Section	Relevant Entity (or Entities) Providing Benefits	Relevant Benefit Classification(s)	Description of Issue for Discussion	Does the Issue for Discussion relate to Operations, Documentation, or Both?	Description of Past and/or Future Action(s) to Address the Issue for Discussion	Issue Resolved - EXPECTED Date	Issue Resolved - ACTUAL Date
O-1	New	All	NQTL	MCO A	Inpatient	MCO A uses plan-developed treatment guidelines for MH/SUD, but uses InterQual for M/S benefits.	Both	9/1/2026: State will follow up with MCO A to ensure that there are comparable treatment guidelines for both MH/SUD and M/S.	12/31/2026	

Step 2: The State should navigate back to the relevant worksheet where the State identified the issue for discussion and add the ID number (found in column A in the Issues for Discussion worksheet) to the relevant cell in the worksheet where the issue was identified. This ID number will always remain the same. This is the final step in entering a new issue for discussion.

For example, if the State identified an issue for discussion in one of the NQTL worksheets, and the State selected that the application to this NQTL is "Not Comparable," the State should update the related "Not Comparable" explanation in the NQTL worksheet to include the ID number (see Figure 33.

Figure 37: Example of Where to Add "Issue for Discussion" ID Number

H	M	N
MCO		
id MCOs in accordance with 42 CFR § 438.910(d). Refer to Instructional Guide section 2.12 for more		
QTLs, all benefit classifications, and all Benefit Package & Entity Providing Benefits information into on		
ion. Note that there is an "other" column available for each NQTL assessment step (e.g., strategy, evi		
mples. Otherwise, leave "other" fields blank.		
		The Strategies below are only exa
Refer to Instructional Guide		***entity's application of this NQTL,***
Comparability and Stringency Assessment Instructions	**Assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organizations**
Comparability: Using the dropdown options in Columns N-AC of this row, assess the comparability of the strategies, evidentiary standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared to the strategies, evidentiary standards, processes, or other factor examples used in applying the NQTL to M/S benefits. If a prepopulated example strategy, evidentiary standard, or process is not used, select 'Not applicable'.		Not comparable
Comparable but not identical: If this option is chosen, explain (using the free text cells in Columns N-AC of this row, as applicable) how and why the State determined that the strategy, evidentiary standard, process, or other factor used in applying the NQTL to MH/SUD benefits is comparable to the strategy, evidentiary standard, process, or other factor used in applying the NQTL to M/S benefits.		
Not Comparable: If this option is chosen, describe the issue (using the free text cells in Columns N-AC of this row, as applicable) and enter the issue in the Issues for Discussion worksheet. Then, (using the free text cells in Columns N-AC of this row, as applicable), report the corresponding ID		MCO A uses plan-developed treatment guidelines for MH/SUD, but uses InterQual for M/S benefits. ID Number O-1.

Scenario 2: Update Existing Entry

Step 1: The State identifies an update to an existing issue for discussion entry (ID Number and entry already exist in the Issues for Discussion worksheet). The State should navigate to the

Issues for Discussion worksheet specific to MCO, CHIP, or ABP and provide updates to the following fields, if applicable:

- ID Number Column (Column A)
  - This field will be auto populated and does not change. No action from the State is necessary. Even if the updated issue for discussion is now resolved, there is no change to the ID Number field. The row should remain in the worksheet and should not be deleted.
- Entry Type Column (Column B)
  - The State should select "Update" from the drop-down options to indicate there is an update to an existing issue for discussion.
- Relevant Benefit Package(s) Column (Column C)
  - If necessary, the State should update the name of the relevant benefit package(s) to which this issue for discussion applies. If there is no update, the State should not change information in this field.
- Relevant Template Section Column (Column D)
  - If necessary, the State should update the selection of the relevant Template section to which this issue for discussion applies. If there is no update, the State should not change information in this field.
- Relevant Entity (or Entities) Providing Benefits Column (Column E)
  - If necessary, the State may update the existing name of the relevant entity(ies) to which this issue for discussion applies. If there is no update, the State should not change information in this field.
- Relevant Benefit Classification(s) Column (Column F)
  - If necessary, the State should update the relevant benefit classification to which this issue for discussion applies. If there is no update, the State should not change information in this field.
- Description of Issue for Discussion Column (Column G)
  - If necessary, the State should update the description of the issue for discussion. The State should keep the existing description and provide the current date, in the format MM/DD/YYYY, next to the updated description. The update history should descend from most recent to oldest. If there is no update, the State should not change information in this field.
- Does the Issue for Discussion relate to Operations, Documentation, or Both? Column (Column H)
  - If necessary, the State should update this field by selecting from the drop-down options, as described below. If there is no update, the State should not change information in this field.
    - **Operations:** If the issue for discussion is still operationally in effect, impacting enrollees and/or providers.
    - **Documentation:** If the issue for discussion has been resolved operationally, but the formal policy or other documentation has not yet been updated accordingly.
    - **Both:** If the issue for discussion is related to both operations and documentation.
- Description of Past and/or Future Action(s) to Address the Issue for Discussion Column (Column I)

- The State should provide an update to the existing description of past and/or future action(s) addressing the issue for discussion, including interactions with managed care plans, CMS, other involved stakeholders, and any State laws, regulations, or policies that require a change. The State should provide updated information. If there is a change to the "Issue Resolved- EXPECTED DATE," the State should explain why the date has changed. If there is a change to the "Issue Resolved- ACTUAL Date," the State should explain how the issue was resolved.
    - When making entries to this field, whether new or updated entries, the State should include a date (MM/DD/YYYY) prior to the free text. Any prior entries should remain in the field, along with the original date. The update history should descend from most recent to oldest.

- Issue Resolved- EXPECTED Date Column (Column J)
    - If the expected date of resolution has changed, the State should update the date it expects the issue will be resolved, in the format MM/DD/YYYY.
- Issue Resolved- ACTUAL Date Column (Column K)
    - If the issue for discussion has been resolved, the State should provide the actual date the issue was resolved, in the format MM/DD/YYYY.

Figure 34 provides an example of an updated issue for discussion.

Figure 38: Example Issues for Discussion Worksheet Showing an "Update" that Resolves an Issue

O. Issues for Discussion - MCO

Refer to Instructional Guide section 2.13 for more detail.

A	B	C	D	E	F	G	H	I	J	K
Auto-Populated									Date. Mm/dd/yyyy	Date. Mm/dd/yyyy
ID Number	Entry Type (New, Update, No changes)	Relevant Benefit Package(s)	Relevant Template Section	Relevant Entity (or Entities) Providing Benefits	Relevant Benefit Classification(s)	Description of Issue for Discussion	Does the Issue for Discussion relate to Operations, Documentation, or Both?	Description of Past and/or Future Action(s) to Address the Issue for Discussion	Issue Resolved - EXPECTED Date	Issue Resolved - ACTUAL Date
O-1	Update	All	NQTL	MCO A	Inpatient	MCO A uses plan-developed treatment guidelines for MH/SUD, but uses InterQual for M/S benefits.	Both	12/10/2026: State discussed needed change with MCO A on 10/15/2026, and necessary change was implemented on 12/1/2026. 9/1/2026: State will follow up with MCO A to ensure that there are comparable treatment guidelines for both MH/SUD and M/S.	12/31/2026	12/1/2026

Step 2: The State should only complete this step if the existing issue for discussion is now resolved. If the issue is now resolved, the State should navigate back to the worksheet where the issue was identified and update the previous responses to reflect that the issue for discussion is now resolved. For example, in one of the NQTL worksheets, if the State had previously selected that the application to this NQTL is "More Stringent" but, after resolution, it is "No More Stringent but Not Identical," the State should update the selection accordingly to reflect a compliant entry and remove previous discussion of the issue as it is no longer applicable. This is the final step in updating the issue for discussion.

<u>Scenario 3: No Changes</u>

Step 1: If the State is submitting updated parity documentation (i.e., an updated Template), the State should navigate to the Issues for Discussion worksheet specific to MCO, CHIP, or ABP. For each existing issue for discussion for which there is no update in this submission, the State should change the following field only:

- Entry Type (Column B)
  - The State should select "No Changes" from the drop-down options to indicate there is no new/updated information added to this existing issue for discussion.

No other action from the State is necessary. Figure 35 provides an example of an issue for discussion entry with no changes.

Figure 39: 40Example Issues for Discussion Worksheet with "No Changes"

O. Issues for Discussion - MCO

Refer to Instructional Guide section 2.13 for more detail.

Auto-Populated									Date. Mm/dd/yyyy	Date. Mm/dd/yyyy
ID Number	Entry Type (New, Update, No changes)	Relevant Benefit Package(s)	Relevant Template Section	Relevant Entity (or Entities) Providing Benefits	Relevant Benefit Classification(s)	Description of Issue for Discussion	Does the Issue for Discussion relate to Operations, Documentation, or Both?	Description of Past and/or Future Action(s) to Address the Issue for Discussion	Issue Resolved - EXPECTED Date	Issue Resolved - ACTUAL Date
O-1	No changes	All	NQTL	MCO A	Inpatient	MCO A uses plan-developed treatment guidelines for MH/SUD, but uses InterQual for M/S benefits.	Both	9/1/2026: State will follow up with MCO A to ensure that there are comparable treatment guidelines for both MH/SUD and M/S.	12/31/2026	

3 Conclusion

This Template is intended to support States in ensuring compliance with Federal parity requirements through improved documentation. The Template aims to clarify and standardize parity documentation requirements, while remaining flexible enough to support the unique needs of the program types that are subject to parity (Medicaid MCO, CHIP, and ABP). CMS recognizes the inherent complexity of parity compliance and understands that States may have questions when completing the Template. For assistance with completing the Template, or for general questions related to documenting parity compliance, States should contact CMS as follows:

- **Medicaid managed care**: DMCO analyst
- **CHIP**: CHIP Project Officer, DSCP
- **ABP**: State Lead, DPO

Appendix

List of Examples of Strategies, Evidentiary Standards, and Processes used in the Design and Application of NQTLs:

- **Examples of strategies:**
  - Excessive utilization or overutilization
  - Cost of care (including variability in cost per episode of care and recent cost escalation)
  - Clinical efficacy of the proposed service (e.g., ensuring the appropriate level of care, intensity of service)
  - Appropriate service duration (e.g., monitoring variation in length of stay)
  - Reliance on treatment guidelines provided by objective third party sources as the clinical rationale when determining medical necessity to approve or deny benefits
  - Deviation from generally accepted standards of care
  - Composition and qualifications of the staff that deliberates, or otherwise makes decisions, on the design of the NQTL
  - Provider discretion in determining a diagnosis or type or length of treatment
  - High levels of variation in length of stay
  - Claim types with high percentage of fraud
  - Current and projected demand for services
  - Severity or chronicity of condition
  - Provider qualifications and capabilities to deliver high quality care
  - Network adequacy (including any formal monitoring of network adequacy by the States, managed care plans or third party)
  - Adherence to or compliance with federal laws, regulations, and policies (e.g., credentialing and contracting requirements, network adequacy)
  - Criteria for coverage of out-of-network services (e.g., emergency care only, lack of providers available in-network for required services)
- **Examples of evidentiary standards:**
  - Professional standards and protocols originating from an objective third party source
  - Clinical treatment/practice guidelines originating from an objective third party source
  - Benchmarks or thresholds (e.g., measures of excessive utilization or other outcome metrics, wait times, provider-to-enrollee ratios, out-of-network utilization rate, time/distance standards)
  - Recognized medical literature or published research originating from an objective third party source
  - Methods used to ensure the consistency of application of evidentiary standards, such as inter-rater reliability testing
  - Internal managed care plan or State FFS program data (e.g., claims or utilization data, market analysis)

  - Credentialing standards, accreditation standards or other guidelines originating from an objective third party source
  - Beneficiary survey data (e.g. CAHPS)
  - Applicable federal laws, regulations, and policies
- **Examples of processes:**
  - Procedures to submit information to authorize coverage for an item or service or otherwise (e.g., online portal, fax, telephone)
  - Types of documentation required to make a determination involving the NQTL (e.g., supporting documentation, application)
  - Timelines for reviewing information or to make a determination involving the NQTL
  - Provider referral requirements
  - Development and approval of a treatment plan
  - Qualifications and/or number of staff involved in NQTL application (e.g., requirements for secondary reviews, consultation with expert reviewers, peer reviews, organization and governance of credentialing committee)
  - Procedures to review and make a determination involving the NQTL (e.g., database checks, peer references)
  - Timelines of screening and enrollment administrative processes (e.g. for reviewing information to make an enrollment determination, timelines for credentialing, contracting, and integration into claim adjudication and payment systems)
  - Resources and technical assistance for providers seeking enrollment, and outreach to providers to encourage enrollment based on area shortages and beneficiary needs)