Instructional Guide for the Mental Health and Substance Use Disorder Parity Plan/State Fee-for-Service Program Reporting Template

September 2024

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Background

The purpose of this Instructional Guide for the Mental Health and Substance Use Disorder Parity Plan/State Fee-for-Service (FFS) Program Reporting Template (from here on referred to as "Guide") is to support States, as well as the entities that provide benefits to Medicaid managed care organization (MCO), Children's Health Insurance Program (CHIP), and/or Alternative Benefit Plan (ABP) enrollees, in documenting compliance with mental health (MH) and substance use disorder (SUD) parity requirements to the Centers for Medicare & Medicaid Services (CMS).[1] The term "managed care plan" is used to refer to Medicaid managed care organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), or Prepaid Ambulatory Health Plans (PAHPs).

This Guide does not contain new parity requirements, and it does not function as a primer of Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requirements' applicability to Medicaid and CHIP. This Guide and the Mental Health and Substance Use Disorder Parity Plan/State FFS Program Reporting Template ("Reporting Template") are intended to standardize and improve documentation of parity compliance, streamline monitoring, and reduce administrative burden for States, managed care plans, and CMS.

MHPAEA and related Medicaid and CHIP regulations[2] apply MH and SUD parity protections to coverage provided to enrollees of Medicaid MCOs, 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.[3]

States may require the entities (i.e., MCOs, PIHPs, PAHPs, and State FFS programs) that provide MH, SUD, and/or M/S benefits in the State to document their parity analyses and compliance with this Reporting Template. CMS developed two versions of this Reporting Template: one for use by managed care plans that references the term "managed care plans," and the other for use by State FFS programs that references the term "State FFS programs." Unless otherwise noted in this Guide, the Plan Reporting Template and the State FFS Reporting Template are identical except for the term itself, "managed care plan" or "State FFS program." The accompanying instructions for the Reporting Templates are also identical, unless otherwise noted in this Guide.

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[1] References to CMS in this Guide and the accompanying Reporting Template pertain to the Center for Medicaid and CHIP Services 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] The regulations implementing MHPAEA are found at 42 CFR § 438, subpart K for managed care, 42 CFR § 457.496 for CHIP, and 42 CFR § 440.395 for ABPs. Throughout this Guide, the term "parity" is used to refer to these mental health and substance use disorder parity requirements, unless otherwise noted.

[3] On September 29, 2023, CMS issued a Request for Comments (RFC) on processes for assessing parity compliance. In response, there was consensus among stakeholders, including those representing States, managed care plans, and advocates, for CMS to provide uniform and standardized templates to improve the effectiveness of documentation of parity compliance by States and managed care plans, and the review of such documentation by CMS.

For conciseness, the term "managed care plan" is used throughout this Guide and is intended to be interchangeable with "State FFS program." For example, where the Guide includes instructions to enter a point of contact for the managed care plan, these same instructions apply for a State FFS program.

This Reporting Template may be used to supplement or replace States' existing means of documenting managed care plan compliance with Federal parity regulations. This Reporting Template complements the State Summary Template by collecting more detailed information from each entity providing benefits in the State, which the State then summarizes and submits to CMS using the State Summary Template.

Overview of Reporting Template Sections

The Reporting Template includes sections for introductory information (i.e., managed care plan data), as well as sections that correspond to the Federal parity requirements for Medicaid managed care plans, CHIPs,[4] and ABPs[5] regarding:

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

The NQTL worksheets are prepopulated with a non-exhaustive prioritized list of five NQTLs, as follows, for each of the four benefit classifications involved in parity (i.e., inpatient, outpatient, emergency care, and prescription drugs):

1. Prior Authorization
2. Concurrent Review
3. Step Therapy/Fail First
4. Standards for Provider Network Admission *(only required for managed care plans establishing a provider network, separate from the FFS network)*
5. Standards for Access to Out-of-Network (OON) Providers *(only required for managed care plans establishing a provider network, separate from the FFS network)*

There are additional NQTL worksheets, which allow the managed care plan to input NQTLs not described in the above list, as needed and/or instructed by the State. In the NQTL worksheets, managed care plans should provide information regarding the strategies, evidentiary standards, processes, and other factors they use to design and apply NQTLs. This information will be used by the State to complete comprehensive NQTL comparative analyses. No additional NQTL

[4] References to CHIP in this document refer to separate CHIPs that must follow the 42 CFR § 457.496 requirements. Title XXI-funded Medicaid expansion CHIPs delivered through managed care must follow the regulations at 42 CFR § 438, subpart K and are considered MCOs for the purposes of the Reporting Template.
[5] See footnote 2 on p. 3 for implementing regulations.

information is required by this workbook. It is the State's responsibility to provide the following information to the managed care plan, prior to the managed care plan completing the Reporting Template:

1. How the State defines conditions (i.e., M/S, MH, SUD);
2. How the State defines each of the benefit classifications (i.e., inpatient, outpatient, emergency care, and prescription drugs);
3. The benefits included in each benefit package and the corresponding condition (i.e., M/S, MH/SUD) and classification for each benefit.

There are a significant number of worksheets included in the Reporting Template, which are intended to encompass a range of potential scenarios and address each of the Federal parity requirement sections for Medicaid managed care plans, CHIPs, and ABPs. As such, all worksheets may not be relevant to each managed care plan; if a worksheet is not applicable to a managed care plan, it should be left blank.[6] For example, if a managed care plan does not apply any FRs (e.g., copayments) in any benefit packages in which they provide benefits, the "E_FR" worksheet should be left blank. Managed care plans should, as applicable, complete the parity analysis at the level of each of the benefit package(s) within which they provide benefits. A managed care plan should report information for Medicaid managed care, CHIP, and ABP benefit packages using the Reporting Template.

The listing below provides an overview of each worksheet included in the Reporting Template; all worksheet titles are denoted with quotations. The following subsections of this Guide will describe each worksheet's structure, purpose, and detailed instructions for completing the Reporting Template.

- Introductory Data Entry (3 worksheets)
  - "A_Instructions"
  - "B_ Managed Care Plan Data" or "State FFS Program Data"
  - "C_All Limits"
- Non-NQTL Parity Analysis (3 worksheets)
  - "D_AL-ADL"
  - "E_FR"
  - "F_QTL"
- NQTL Parity Analysis (24 worksheets)[7]
  - "G_NQTL Prior Auth-IP"
  - "H_NQTL Prior Auth-OP"
  - "I_NQTL Prior Auth-EC"

[6] Additionally, there are decision support tools (e.g., input messages, greying-out cells based on responses) to support the user in navigating the Reporting Template.

[7] The Reporting Template worksheet titles are abbreviated due to character limits in Excel for worksheet titles. The benefit classifications are abbreviated as follows: "inpatient" as "IP," "outpatient" as "OP," "emergency care" as "EC," and "prescription drugs" as "PD." The NQTLs that required abbreviation are as follows: "Prior Authorization" as "Prior Auth," "Standards for Provider Network Admission" as "Network Admit," and "Standards for Access to Out-of-Network (OON) Providers" as "OON Providers."

  - "J_NQTL Prior Auth-PD"
  - "K_NQTL Concurrent Review-IP"
  - "L_NQTL Concurrent Review-OP"
  - "M_NQTL Concurrent Review-EC"
  - "N_NQTL Concurrent Review-PD"
  - "O_NQTL StepTherapyFailFirst-IP"
  - "P_NQTL StepTherapyFailFirst-OP"
  - "Q_NQTL StepTherapyFailFirst-EC"
  - "R_NQTL StepTherapyFailFirst-PD"
  - "S_NQTL NetworkAdmit-IP"
  - "T_NQTL NetworkAdmit-OP"
  - "U_NQTL NetworkAdmit-EC"
  - "V_NQTL NetworkAdmit-PD"
  - "W_NQTL OONProviders-IP"
  - "X_NQTL OONProviders-OP"
  - "Y_NQTL OONProviders-EC"
  - "Z_NQTL OONProviders-PD"
  - "AA_NQTL Other1"
  - "AB_NQTL Other2"
  - "AC_NQTL Other3"
  - "AD_NQTL Other4"
- Issues for Discussion (1 worksheet)
  - "AE_Issues for Discussion"

Some worksheets include functionality (e.g., drop-downs, formulas) that prevent the user from reporting data other than the options presented. Additionally, the overall layout of the worksheets, including row and column counts, is locked so no additional rows or columns can be added. Note that each cell has a 32,767 character limit for responses. Additionally, many of the worksheets require the managed care plan to "attest to," "describe," or otherwise provide a response to questions or statements that are based on the Federal parity requirements for Medicaid managed care plans, CHIPs, and ABPs. As described, States may use the Reporting Template to collect parity information from their managed care plans; thus "attest to," "describe," or other similar language is solely intended to elicit a response from the managed care plan.

If managed care plans need to provide additional information that could not be entered through the Reporting Template, they should contact State Medicaid and CHIP program staff, who in turn may need to contact CMS.

Instructions

The "A_Instructions" worksheet includes a linked table of contents for all worksheets in the Reporting Template. The Instructions worksheet is a reference and does not require managed care plan data entry.

Managed Care Plan or State FFS Program Data

The managed care plan should complete the following introductory data elements before beginning the parity analysis worksheets. The following is required:

- **State:**
  - Select the State associated with the information reporting in this Reporting Template from the drop-down options.
- **Managed Care Plan:**
  - Indicate the managed care plan name, which should be consistent with the name of the managed care plan in the State's contract with its managed care plans.
- **Managed Care Plan Contact Name:**
  - Indicate the first and last name of the main point of contact for the parity documentation.
- **Managed Care Plan Contact Title:**
  - Indicate the title of the main point of contact for the parity documentation.
- **Managed Care Plan Contact Phone Number:**
  - Indicate the phone number for the main point of contact.
- **Managed Care Plan Contact Email Address:**
  - Indicate the email address for the main point of contact.
- **Alternative Managed Care Plan Contact Name:**
  - Indicate the first and last name of an alternative point of contact for the parity documentation.
- **Alternative Managed Care Plan Contact Title:**
  - Indicate the title of the alternative point of contact for the parity documentation.
- **Alternative Managed Care Plan Contact Phone Number:**
  - Indicate the phone number for the alternative point of contact.
- **Alternative Managed Care Plan Contact Email Address:**
  - Indicate the email address for the alternative point of contact.

The managed care plan should also provide the following background details related to the information included in the Reporting Template:

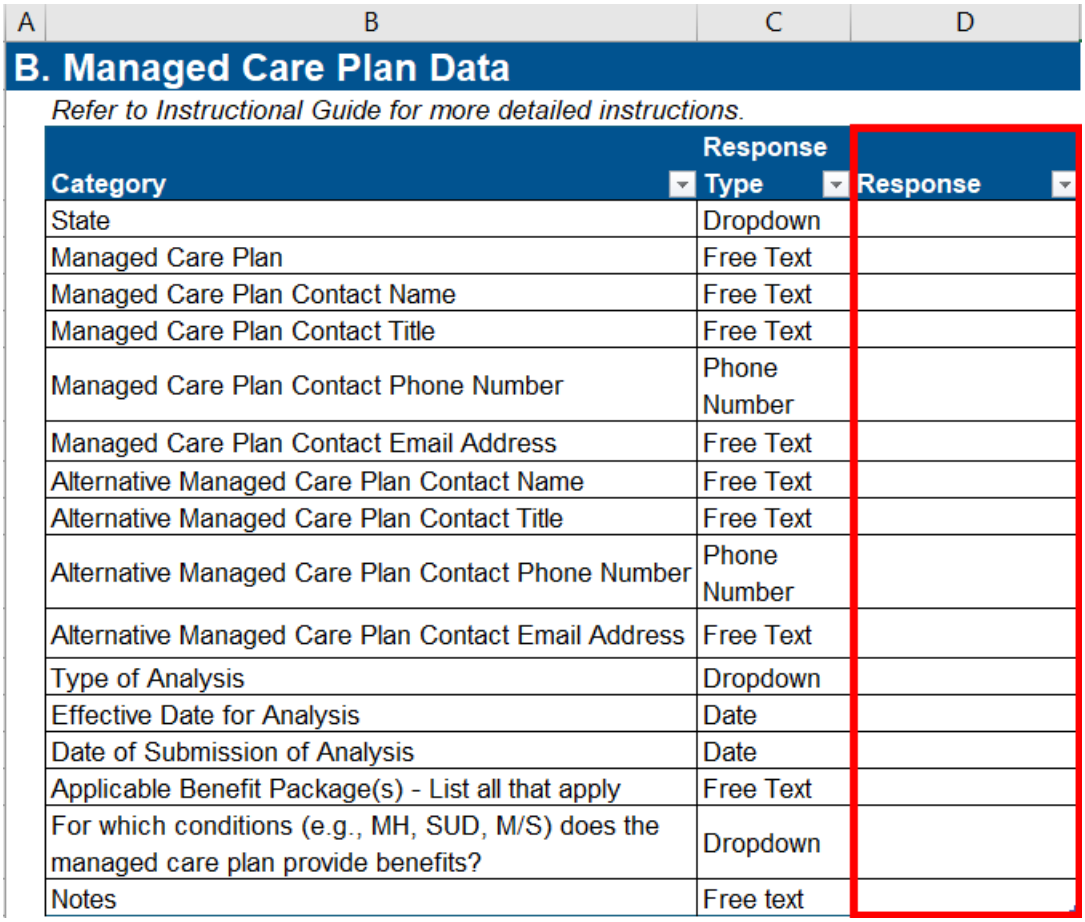
- **Type of Analysis**
  - The managed care plan should select from a list of drop-down options, as follows:
    - New Program
    - New Managed Care Plan to Program
    - Updates Due to Benefit, AL-ADL, FR, QTL, or NQTL Change or Deficiencies Corrected
    - Other
- **Effective Date for Analysis**

- This is the date in which the type of analysis (described in the above field) was implemented. For example, if the managed care plan is newly contracted with the State, the date of implementation for analysis is the effective date of this contract.

- **Date of Submission of Analysis**
  - This is the date on which the managed care plan submits the analysis, in the form of this Reporting Template, to the State.
- **Applicable Benefit Package(s) – List all that apply:**
  - The managed care plan should list all benefit package(s) for which it provides MH, SUD, and/or M/S benefits in the State. A benefit package includes all benefits provided to a specific population group (e.g., children, adults, individuals with a nursing facility level of care) regardless of delivery system.[8]
- **For which conditions (e.g., MH, SUD, M/S) does the managed care plan provide benefits?**
  - The managed care plan should select from the drop-down options for which type of conditions they provide benefits (e.g., MH, SUD, M/S). The drop-down options are as follows:
    - MH
    - SUD
    - M/S
    - MH and SUD
    - MH, SUD, and M/S
    - MH and M/S
    - SUD and M/S
- **Notes:**
  - As needed, the managed care plan should provide any notes or clarifications.

[8] CMS Center for Medicaid and CHIP Services *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

Figure 1: "B_ Managed Care Plan Data" Worksheet Overview



B. Managed Care Plan Data

Refer to Instructional Guide for more detailed instructions.

Category	Response Type	Response
State	Dropdown	
Managed Care Plan	Free Text	
Managed Care Plan Contact Name	Free Text	
Managed Care Plan Contact Title	Free Text	
Managed Care Plan Contact Phone Number	Phone Number	
Managed Care Plan Contact Email Address	Free Text	
Alternative Managed Care Plan Contact Name	Free Text	
Alternative Managed Care Plan Contact Title	Free Text	
Alternative Managed Care Plan Contact Phone Number	Phone Number	
Alternative Managed Care Plan Contact Email Address	Free Text	
Type of Analysis	Dropdown	
Effective Date for Analysis	Date	
Date of Submission of Analysis	Date	
Applicable Benefit Package(s) - List all that apply	Free Text	
For which conditions (e.g., MH, SUD, M/S) does the managed care plan provide benefits?	Dropdown	
Notes	Free text	

All Limits

Overall Layout and Instructions

The "C_All Limits" worksheet includes a set of questions regarding the application of AL-ADLs, FRs, and treatment limitations ***applied to MH/SUD benefits*** which will guide a managed care plan to complete, as necessary, the subsequent "D_AL-ADL," "E_FR," and/or "F_QTL" worksheets, as well as the applicable NQTL worksheets.

If the managed care plan answers "Yes" to applying ALs and/or ADLs to MH/SUD benefits in any ***Medicaid managed care*** benefit package, the managed care plan should complete the "D_AL-ADL" worksheet. If the managed care plan answers "Yes" to this question for CHIP benefit packages or for essential health benefits (EHBs) delivered through ABP benefit packages,

this should be reported in the "AE_Issues for Discussion" worksheet.[9] [10] Managed care plans must share issues related to parity compliance with States; the "AE_Issues for Discussion" worksheet will be further explained in its section of this Guide.

If the managed care plan applies FRs (e.g., copayments) to any MH/SUD benefits in any benefit package in the inpatient, outpatient, or emergency care benefit classifications, the managed care plan should complete the "E_FR" worksheet.

There are separate instructions related to the special rule for multi-tiered prescription drugs.[11] ***If the managed care plan does not apply different levels of FRs to different tiers of prescription drug benefits, but it applies FRs to MH/SUD benefits in any benefit package in the prescription drug benefit classification***, the managed care plan should answer "Yes" to ID# C-4, "No" to ID# C-5, "No" to ID# C-6, and "NA" to ID# C-7. The managed care plan should then complete the "E_FR" worksheet.

If the managed care plan 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, ***the managed care plan should not complete the "E_FR" worksheet.*** Instead, in ID# C-7, the managed care plan should describe the reasonable factor (e.g., cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up/delivery).[12] If the managed care plan 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 managed care plan should complete the "E_FR" worksheet.

If the managed care plan applies QTLs (e.g., day limits) to MH/SUD benefits in any benefit package in any benefit classification, the managed care plan should complete the "F_QTL" worksheet.

If the managed care plan applies NQTLs (e.g., prior authorization) to MH/SUD benefits in any benefit package in any benefit classification, the managed care plan should complete, as necessary based on the NQTL(s) that the managed care plan applies, the applicable NQTL worksheet(s). As described above, the NQTL worksheets are specific to the prioritized list of five NQTLs per the four benefit classifications as well as the "Other" NQTL worksheets.

In the below example of a completed "C_All Limits" worksheet, the managed care plan does not need to complete the "D_AL-ADL" worksheet because it attested that it does not apply ALs or ADLs to MH/SUD benefits (IDs# C-1-2). The managed care plan attested that it applies FRs in

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[9] 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. 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) (to be codified at 42 CFR § 457.480).

[10] ABP parity regulations at 42 CFR §440.395 do not include provisions related to AL-ADLs. However, under 42 C.F.R. § 440.395(c), "Annual or lifetime limits are not permissible in EPSDT benefits."

[11] 42 CFR § 438.910(c)(2)(i), 42 CFR § 457.496(d)(3)(ii)(A), 42 CFR § 440.395(b)(3)(ii)(A) for Medicaid MCO, CHIP, and ABP, respectively.

[12] See footnote 11.

the inpatient, outpatient, or emergency care benefit classification (ID# C-3), so it will need to complete the "E_FR" worksheet. The managed care plan attested that it does not apply FRs for the prescription drug benefit classification (ID# C-4) and therefore does not meet the conditions described in IDs# C-5-7; as a result of indicating "No" to ID# C-4, IDs# C-5-7 automatically format with grey cells as demonstrated in Figure 2 below. The managed care plan attested that it does not apply QTLs to any MH/SUD benefits (ID# C-8), so it does not need to complete the "F_QTL" worksheet. Finally, the managed care plan attested that it applies NQTLs to MH/SUD benefits (ID# C-9), so it will need to complete one or more of the NQTL worksheets, which are specific to the prioritized list of NQTLs per benefit classification as well as the "Other" NQTL worksheets. See Figure 2 for a demonstration of this scenario.

Figure 2: Sample "C_All Limits" Worksheet

C. All Financial Requirements and Treatment Limitations

General Section - Aggregate Lifetime and Annual Dollar Limits, Financial Requirements, Quantitative Treatment Limits, and Nonquantitative Treatment Limitations
Refer to Instructional Guide for more detailed instructions.

ID Numb	Question	Response Type	Response	Instructions
C-1	Does the managed care plan apply aggregate lifetime dollar limit(s) (AL) to MH/SUD benefits in any benefit package?	Dropdown	No	If Yes for Medicaid managed care benefit packages, complete the AL-ADL worksheet. If Yes for CHIP benefit packages or for EHBs delivered through ABP benefit packages, report in Issues for Discussion worksheet.
C-2	Does the managed care plan apply annual dollar limit(s) (ADL) to MH/SUD benefits in any benefit package?	Dropdown	No	If Yes for Medicaid managed care benefit packages, complete the AL-ADL worksheet. If Yes for CHIP benefit packages or for EHBs delivered through ABP benefit packages, report in Issues for Discussion worksheet.
C-3	For the inpatient, outpatient, or emergency care benefit classifications, does the managed care plan apply any financial requirement(s) (FR) to any MH/SUD benefits in any benefit package?	Dropdown	Yes	If Yes, complete the FR worksheet.
C-4	For the prescription drug benefit classification, does the managed care plan apply FRs to any MH/SUD benefits in any benefit package?	Dropdown	No	If Yes, respond to #5.
C-5	If Yes to #4, does the managed care plan apply different levels of FRs to different tiers of prescription drug benefits in any benefit package?	Dropdown		If No, complete the FR worksheet. If Yes, respond to #6.
C-6	If Yes to #5, does the managed care plan 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 § 440.395(b)(3)(ii)(A), 42 CFR § 457.496(d)(3)(ii)(A), and 42 CFR § 438.910(c)(2)(i)?	Dropdown		If No, complete the FR worksheet and describe why the managed care plan could not answer "Yes" in the Issues for Discussion worksheet.
C-7	If Yes to #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 § 440.395(b)(3)(ii)(A), 42 CFR § 457.496(d)(3)(ii)(A), and 42 CFR § 438.910(c)(2)(i).	Free Text		If Yes to #6 and the managed care plan provided an explanation of reasonable factors, there is no need to complete the FR worksheet.
C-8	Does the managed care plan 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 worksheet.
C-9	Does the managed care plan 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 NQTL worksheet for each NQTL and benefit classification, as applicable.

Aggregate Lifetime and Annual Dollar Limits

Regulatory basis for the section

Medicaid managed care: 42 CFR § 438.905

Overall Layout

If the managed care plan indicates that it applied ALs or ADLs for MH/SUD benefits in any benefit package, the managed care plan should complete the "D_AL-ADL" worksheet. The

managed care plan should complete a set of questions (IDs# D-1-13) ***for each benefit package in which the managed care plan provides benefits and ALs and/or ADLs are applied.*** For example, if there are two benefit packages, Benefit Package 1 and Benefit Package 2, the managed care plan should complete questions ID#s D-1-13 for Benefit Package 1 and again, separately, complete another set of questions IDs D-1-13 for Benefit Package 2. See Figure 3 for an example of managed care plan that applied an AL in one benefit package.

Figure 3: Sample "D_AL-ADL" Worksheet – One Benefit Package with an AL

D. Aggregate Lifetime Dollar Limits and Annual Dollar Limits

This section relates to AL/ADLs applied to benefits delivered to enrollees of Medicaid managed care plans in accordance with 42 CFR § 438.905. Please note that AL/ADLs cannot be a and for essential health benefits (EHBs) delivered to Alternative Benefit Plan (ABP) enrollees, regardless of delivery system. Refer to Instructional Guide for more detailed instructions.

ID Numb	Benefit Package	Question	Response Typ	Response
D-1	Benefit Package 1	If the managed care plan provides MH/SUD benefits, describe the aggregate lifetime dollar limit (AL) or annual dollar limit (ADL) applied to MH/SUD benefits using the applicable column(s).	Free Text	AL of $1,000,000.00 on X Benefits
D-2	Benefit Package 1	If the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for all M/S benefits subject to the AL or ADL in a contract year?	Number	$7,000,000.00
D-3	Benefit Package 1	If the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for all M/S benefits in a contract year?	Number	$10,000,000.00
D-4	Benefit Package 1	If the managed care plan provides M/S benefits, what is the percentage of all expected payments for all M/S benefits subject to the AL or ADL in a contract year?	Percentage. Auto calculated Field	70.00%
D-5	Benefit Package 1	If the managed care plan provides M/S benefits, does the AL or ADL apply to less than 1/3 of all M/S benefits?	Dropdown	No
D-6	Benefit Package 1	If Yes to #5 and if the managed care plan provides M/S and MH/SUD benefits, explain why the limit is still applied to MH/SUD benefits despite not meeting the requirements in 42 CFR § 438.905(b) and report it to the State in the Issues for Discussion worksheet.	Free Text	
D-7	Benefit Package 1	If No to #5 and if the managed care plan provides M/S benefits, does the AL or ADL apply to at least 2/3 of all M/S benefits?	Dropdown	Yes
D-8	Benefit Package 1	If Yes to #7 and if the managed care plan provides M/S and MH/SUD benefits, describe how the managed care plan applies the AL or ADL to both M/S and MH/SUD benefits in a manner that does not distinguish between M/S and MH/SUD benefits.	Free Text	The managed care plan applies an AL of $1,000,000 on both X MH/SUD and Y M/S benefits.
D-9	Benefit Package 1	If Yes to #7, if the managed care plan cannot describe in #8 how 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, and if the managed care plan provides M/S and MH/SUD benefits, describe how the managed care plan's application of the AL or ADL to MH/SUD benefits is not more restrictive than it is for M/S benefits.	Free Text	NA
D-10	Benefit Package 1	If the managed care plan cannot describe either #8 or #9 and if the managed care plan provides M/S and MH/SUD benefits, explain why the limit is still applied to MH/SUD benefits despite not meeting the requirements in 42 CFR § 438.905(c) and report it to the State in the Issues for Discussion worksheet.	Free Text	NA
D-11	Benefit Package 1	If No to #5 and #7 (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) and if the managed care plan provides M/S and MH/SUD benefits, describe how the managed care plan's application of the AL or ADL to MH/SUD benefits is not more restrictive than an average limit calculated for M/S benefits using the weighted average of the ALs or ADLs, as appropriate, that are applicable to the categories of M/S benefits.	Free Text	
D-12	Benefit Package 1	If the managed care plan described in #11 how its application of the AL or ADL on MH/SUD benefits is not more restrictive than an average limit calculated for M/S benefits using the weighted average of the ALs or ADLs, as appropriate, that is applicable to the categories of M/S benefits and the managed care plan provides M/S benefits, what is the average limit?	Number	
D-13	Benefit Package 1	If the managed care plan did not describe in #11 how its application of the AL or ADL on MH/SUD benefits is not more restrictive than an average limit calculated for M/S benefits using the weighted average of the ALs or ADLs, as appropriate, that is applicable to the categories of M/S benefits and the managed care plan provides M/S and MH/SUD benefits, explain why the limit is still applied to MH/SUD benefits despite not meeting the requirements in 42 CFR § 438.905(e)(1)(ii) and report it to the State in the Issues for Discussion worksheet.	Free Text	

All questions are in the Question Column (Column D), while the Response Columns (Columns F-M) relate to responses for ***different types of ALs or ADLs***, as applicable. The questions in Column D (IDs# D-1-13) should be answered for each type of AL or ADL indicated in response to ID# D-1 across Columns F-M (the managed care plan should use as many columns as necessary to capture all ALs or ADLs within each benefit package).

Instructions

As discussed, the managed care plan should indicate the type of AL or ADL in ID# D-1. If a managed care plan provides M/S benefits, the managed care plan should then complete a cost analysis to determine the total dollar amount of expected payments for all M/S benefits subject to

the AL or ADL in a contract year (ID# D-2) and the total dollar amount of expected payments for all M/S benefits in a contract year (ID# D-3). The percentage, included as a formula, in ID# D-4 is the calculation of the amount indicated in ID# D-2 divided by the amount indicated in ID# D-3. The remaining questions (IDs# D-5-13) are related to if the percentage in ID# D-4 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.

- IDs# D-5-6: If the percentage in ID# D-4 is less than 33.3% of all M/S benefits, the managed care plan should not apply the AL or ADL to MH/SUD benefits per the Federal parity requirements.[13] If the managed care plan applies the AL or ADL, it should explain why the limit is still applied to MH/SUD benefits despite not meeting the requirements at 42 CFR § 438.905(b) and report it to the State using the "AE_Issues for Discussion" worksheet.
- IDs# D-7-10: If the percentage in ID# D-4 is more than 66.7% of all M/S benefits, the managed care plan should describe whether it applies the AL or ADL to both M/S and MH/SUD benefits in a manner that does not distinguish between the M/S and MH/SUD benefits (ID# D-8), or whether its application of the AL or ADL to MH/SUD benefits is not more restrictive than it is for M/S benefits (ID# D-9).
    - If the percentage in ID# D-4 is more than 66.7% of all M/S benefits and if the managed care plan cannot describe either of these two options (ID# D-8 or D-9), it should explain why the limit is still applied to MH/SUD benefits despite not meeting the requirements at 42 CFR § 438.905(c) and report it to the State using the "AE_Issues for Discussion" worksheet.
- IDs# D-11-13: If the percentage in ID# D-4 is between 33.3% and 66.7% of all M/S benefits (e.g., if the percentage is 55%), the managed care plan should describe how its application of the AL or ADL to MH/SUD benefits is not more restrictive than an average limit calculated for M/S benefits using the weighted average of the ALs or ADLs, as appropriate, that is applicable to the categories of M/S benefits.[14]
    - If the managed care plan describes the above (ID# D-11), it should provide the average limit in ID# D-12.
    - If the managed care plan cannot describe in ID# D-11 how its application of the ALs or ADLs to MH/SUD benefits is not more restrictive than an average limit calculated for M/S benefits using the weighted average of the AL or ADL, as appropriate, that is applicable to the categories of M/S benefits, it should explain why the limit is still applied to MH/SUD benefits despite not meeting the requirements at 42 CFR § 438.905(e)(1)(ii) and report it to the State using the "AE_Issues for Discussion" worksheet.

[13] See 42 CFR § 438.905.
[14] See 42 CFR § 438.905(e)(1)-(2)

Financial Requirements

Regulatory basis for the section

Medicaid managed care: 42 CFR § 438.910(a)-(c)

CHIP: 42 CFR § 457.496(d)(1)-(3)

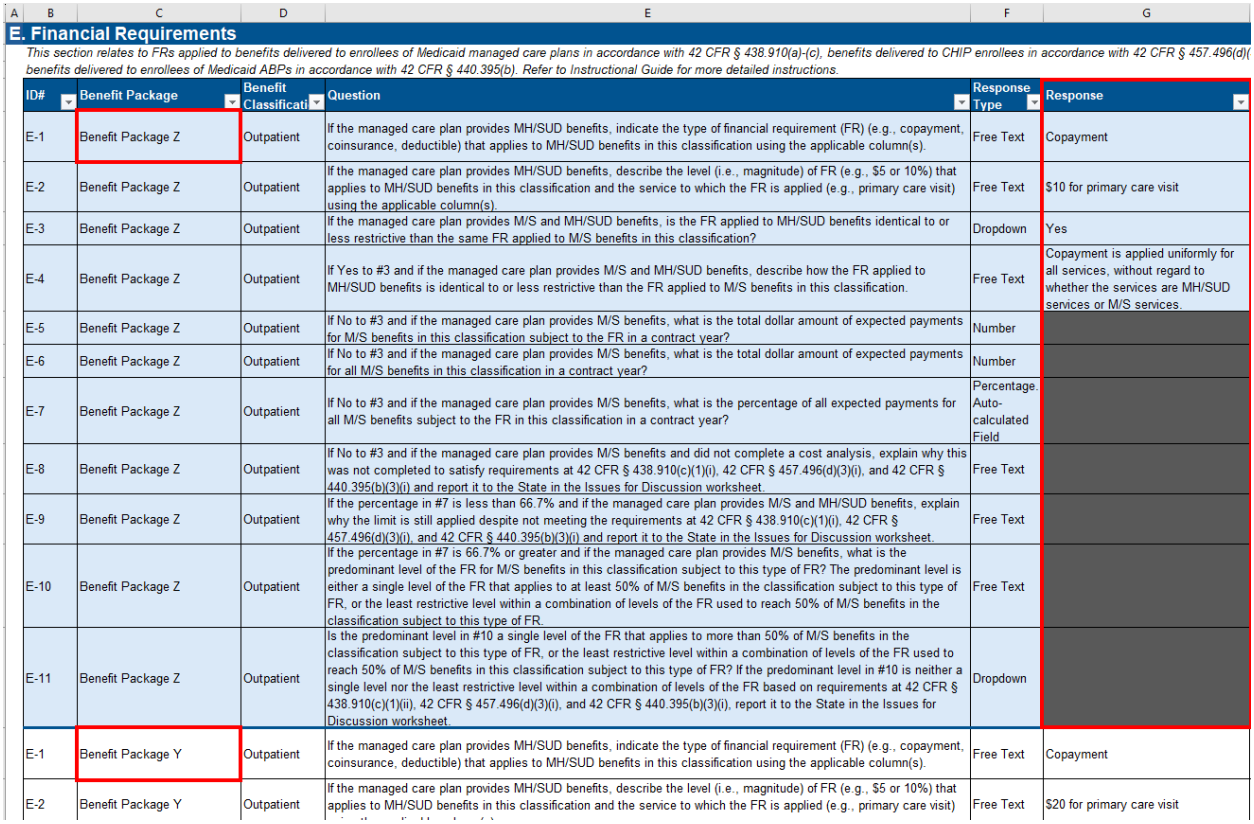
ABP: 42 CFR § 440.395(b)(1)-(3)

Overall Layout

If the managed care plan applies FRs to MH/SUD benefits in the inpatient, outpatient, or emergency care classifications, the managed care plan should complete the 'E_FR' worksheet. Additionally, if the managed care plan does not apply different levels of FRs to different tiers of prescription drug benefits (but does apply FRs to MH/SUD prescription drug benefits), the managed care plan should complete the "E_FR" worksheet. If the managed care plan applies different levels of FRs to different tiers of prescription drug benefits but does not use a reasonable method to apply such levels as described earlier in these instructions, the managed care plan should complete the "E_FR" worksheet and describe why it could not answer "Yes" to using a reasonable method in the "AE_Issues for Discussion" worksheet.

The managed care plan should complete a set of questions (IDs# E-1-11) ***for each benefit package for which the managed care plan provides benefits and for which FRs are applied.*** See Figure 4 for an example of a managed care plan applying a copayment in two different benefit packages; the managed care plan should complete questions IDs# E-1-11 separately for each benefit package.

Figure 4: Sample "E_FR" Worksheet – FR applied across two Benefit Packages



E. Financial Requirements

This section relates to FRs applied to benefits delivered to enrollees of Medicaid managed care plans in accordance with 42 CFR § 438.910(a)-(c), benefits delivered to CHIP enrollees in accordance with 42 CFR § 457.496(d)(benefits delivered to enrollees of Medicaid ABPs in accordance with 42 CFR § 440.395(b). Refer to Instructional Guide for more detailed instructions.

ID#	Benefit Package	Benefit Classificati	Question	Response Type	Response
E-1	Benefit Package Z	Outpatient	If the managed care plan provides MH/SUD benefits, 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
E-2	Benefit Package Z	Outpatient	If the managed care plan provides MH/SUD benefits, 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 for primary care visit
E-3	Benefit Package Z	Outpatient	If the managed care plan provides M/S and MH/SUD benefits, 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
E-4	Benefit Package Z	Outpatient	If Yes to #3 and if the managed care plan provides M/S and MH/SUD benefits, 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	Copayment is applied uniformly for all services, without regard to whether the services are MH/SUD services or M/S services.
E-5	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for M/S benefits in this classification subject to the FR in a contract year?	Number	
E-6	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for all M/S benefits in this classification in a contract year?	Number	
E-7	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the percentage of all expected payments for all M/S benefits subject to the FR in this classification in a contract year?	Percentage. Auto-calculated Field	
E-8	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits and did not complete a cost analysis, explain why this was not completed to satisfy requirements at 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) and report it to the State in the Issues for Discussion worksheet.	Free Text	
E-9	Benefit Package Z	Outpatient	If the percentage in #7 is less than 66.7% and if the managed care plan provides M/S and MH/SUD benefits, explain why the limit is still applied despite not meeting the requirements at 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) and report it to the State in the Issues for Discussion worksheet.	Free Text	
E-10	Benefit Package Z	Outpatient	If the percentage in #7 is 66.7% or greater and if the managed care plan provides M/S benefits, 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 of the FR used to reach 50% of M/S benefits in the classification subject to this type of FR.	Free Text	
E-11	Benefit Package Z	Outpatient	Is the predominant level in #10 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? If the predominant level in #10 is neither a single level nor the least restrictive level within a combination of levels of the FR based on requirements at 42 CFR § 438.910(c)(1)(ii), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i), report it to the State in the Issues for Discussion worksheet.	Dropdown	
E-1	Benefit Package Y	Outpatient	If the managed care plan provides MH/SUD benefits, 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
E-2	Benefit Package Y	Outpatient	If the managed care plan provides MH/SUD benefits, 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)	Free Text	$20 for primary care visit

Each set of questions (IDs# E-1-11) relates to one benefit classification only. The managed care plan should select from the drop-down options (i.e., inpatient, outpatient, emergency care, and prescription drugs) to indicate in which benefit classification the FRs are applied in the Benefit Classification Column (Column D). If FRs are applied in the inpatient and outpatient benefit classifications, for example, the managed care plan should complete the question set (IDs# E-1-11) once for the inpatient classification and again, separately, for the outpatient classification.

All questions are in the Question Column (Column E), while the Responses Columns (Columns G-L) relate to responses for ***different types of FRs*** (e.g., copayments, coinsurance, deductibles), as applicable. The questions in Column E (IDs# E-1-11) should be answered for each type of FR indicated in response to ID# E-1 across Columns G-L (the managed care plan should use as many columns as necessary to capture all FRs within each benefit package). For example, if a managed care plan applies both copayments and coinsurance to MH/SUD benefits, it should enter the copayments in ID# E-1, Column G, and the coinsurance in ID# E-1, Column H. An example of this scenario is provided in Figure 5 below.

Figure 5: Sample of "'E_FR" Worksheet – Copayment and Coinsurance for one Benefit Package

E. Financial Requirements

This section relates to FRs applied to benefits delivered to enrollees of Medicaid managed care plans in accordance with 42 CFR § 438.910(a)-(c), benefits delivered to CHIP enrollees in accordance with 42 CFR § 457.496(d)(3), and benefits delivered to enrollees of Medicaid ABPs in accordance with 42 CFR § 440.395(b). Refer to Instructional Guide for more detailed instructions.

ID#	Benefit Package	Benefit Classificati	Question	Response Type	Response	Response2
E-1	Benefit Package Z	Outpatient	If the managed care plan provides MH/SUD benefits, 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	Coinsurance
E-2	Benefit Package Z	Outpatient	If the managed care plan provides MH/SUD benefits, 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 for primary care visit	10% for specialist visit
E-3	Benefit Package Z	Outpatient	If the managed care plan provides M/S and MH/SUD benefits, 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	No
E-4	Benefit Package Z	Outpatient	If Yes to #3 and if the managed care plan provides M/S and MH/SUD benefits, 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	Copayment is applied uniformly for all services, without regard to whether the services are MH/SUD services or M/S services.	
E-5	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for M/S benefits in this classification subject to the FR in a contract year?	Number		$2,500,000.00
E-6	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for all M/S benefits in this classification in a contract year?	Number		$3,000,000.00
E-7	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the percentage of all expected payments for all M/S benefits subject to the FR in this classification in a contract year?	Percentage. Auto-calculated Field		83.33%
E-8	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits and did not complete a cost analysis, explain why this was not completed to satisfy requirements at 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) and report it to the State in the Issues for Discussion worksheet.	Free Text		NA
E-9	Benefit Package Z	Outpatient	If the percentage in #7 is less than 66.7% and if the managed care plan provides M/S and MH/SUD benefits, explain why the limit is still applied despite not meeting the requirements at 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) and report it to the State in the Issues for Discussion worksheet.	Free Text		NA
E-10	Benefit Package Z	Outpatient	If the percentage in #7 is 66.7% or greater and if the managed care plan provides M/S benefits, 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 of the FR used to reach 50% of M/S benefits in the classification subject to this type of FR.	Free Text		10%
E-11	Benefit Package Z	Outpatient	Is the predominant level in #10 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? If the predominant level in #10 is neither a single level nor the least restrictive level within a combination of levels of the FR based on requirements at 42 CFR § 438.910(c)(1)(ii), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i), report it to the State in the Issues for Discussion worksheet.	Dropdown		Single Level

Instructions

As discussed, the managed care plan should indicate the type of FR ***that applies to MH/SUD benefits*** in ID# E-1. For example, the managed care plan should indicate "copayments" in ID# E-1, Column G, if there are copayments that apply to MH/SUD benefits within benefit package(s) and within one benefit classification. In ID# E-2, the managed care plan should then describe the level or magnitude of the FR indicated in ID# E-1. For example, the copayment may be $5 for an outpatient primary care visit; $5 is the level of the copayment. In ID# E-2, the managed care plan should also describe for which type of services (in the prior example, an outpatient primary care visit) the FR is applied within the classification; see Figure 4 above for an example of this in ID# E-2.

The next two questions (IDs# E-3-4) are intended to streamline the managed care plan's parity documentation, if applicable. If the managed care plan provides both MH/SUD and M/S benefits and can attest in ID# E-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 the managed care plan provides a description of how this is the case in ID# E-4 – the managed care plan does not need to answer the remaining questions in the set (IDs# E-5-11).[15] For example, if the copayment for an inpatient admission is $100 for both MH/SUD and M/S benefits in a given benefit package, then the copayments for MH/SUD and M/S benefits are

[15] See Analysis of Financial Requirements, Quantitative Treatment Limitations, and Aggregate Lifetime and Annual Dollar Limits, Tip 5a in Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs at p. 22.

identical. The copayment for an inpatient admission in this example is applied uniformly for all benefits, regardless of whether they are MH/SUD or M/S benefits. In this case, the managed care plan does not need to complete IDs# E-5-11.

If the managed care plan 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 managed care plan is not able to provide a description of how this is the case, the managed care plan should complete the remaining questions in the set (IDs# E-5-11), as applicable.

In ID# E-5, if a managed care plan provides M/S benefits, the managed care plan should record the results of its cost analysis to indicate the total dollar amount of expected payments for all M/S benefits subject to the FR in a contract year (ID# E-5) and the total dollar amount of expected payments for all M/S benefits in a contract year (ID# E-6). The managed care plan should attach its detailed cost analysis with the Reporting Template upon submission. The percentage (included as a formula in ID# E-7) is the calculation of the amount indicated in ID# E-5 divided by the amount indicated in ID# E-6. If the managed care plan cannot provide a cost analysis in IDs# E-5-7, it should explain why the cost analysis was not completed in ID# E-8 and report this information to the State using the "AE_Issues for Discussion" worksheet.

ID# E-9: If the percentage in ID# E-7 is less than 66.7%, the FR cannot be applied to MH/SUD benefits in the benefit classification per Federal parity requirements.[16] The managed care plan should explain why the FR is still applied despite not meeting these requirements and report it to the State using the "AE_Issues for Discussion" worksheet.

IDs# E-10-11: If the percentage in ID# E-7 is 66.7% or greater, the managed care plan should enter the predominant level of the FR in ID #E-10. The predominant level is either a single level of the FR (e.g., $5) that applies to more than half (i.e., 50%) of M/S benefits in the classification that are subject to that 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 the classification that are subject to that type of FR. For the predominant level provided in response to ID# E-10, the managed care plan should indicate using the drop-down options for the response to ID# E-11 if it used a single level of the FR that applies to more than 50% of M/S benefits subject to that type of FR ("Single Level") or if it used the least restrictive level within a combination of levels of the FR used to reach 50% of M/S benefits subject to that type of FR ("Least Restrictive within Combination of Levels").[17] If the managed care plan applies a level of the FR ***to MH/SUD benefits*** that is more restrictive than this predominant level of FR,[18] the managed care plan should report it to the State using the "AE_Issues for Discussion" worksheet.

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[16] 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) for Medicaid managed care, CHIP, and ABP, respectively.

[17] 42 CFR § 438.910(c)(1)(ii), 42 CFR § 457.496(d)(3)(i), 42 CFR § 440.395(b)(3)(i) for Medicaid managed care, CHIP, and ABP, respectively.

[18] See footnote 16.

Quantitative Treatment Limitations

Regulatory basis for the section

Medicaid managed care: 42 CFR § 438.910(a)-(c)

CHIP: 42 CFR § 457.496(d)(1)-(3)

ABP: 42 CFR § 440.395(b)(1)-(3)

Overall Layout

If the managed care plan applies QTLs to MH/SUD benefits in any benefit classification, the managed care plan should complete the "F_QTL" worksheet.

The managed care plan should complete a set of questions (IDs# F-1-11) ***for each benefit package for which the managed care plan provides benefits and QTLs are applied.***

Each set of questions (IDs# F-1-11) relates to one benefit classification only. The managed care plan should select from the drop-down options (i.e., inpatient, outpatient, emergency care, prescription drugs) to indicate in which benefit classification the QTLs are applied in the Benefit Classification Column (Column D). If QTLs are applied in the inpatient and outpatient benefit classifications, the managed care plan should complete the question set (IDs# F-1-11) once for the inpatient classification and again, separately, for the outpatient classification.

All questions are in Column E, while Columns G-L relate to ***different types of QTLs*** (e.g., episode, day, or visit limits), as applicable. The questions in Column E (IDs# F-1-11) should be answered for each type of QTL indicated in response to ID# F-1 across Columns G-L (the managed care plan should use as many columns as necessary to capture all QTLs within each benefit package). For example, if a managed care plan applies both day limits and episode limits to MH/SUD benefits, it should enter the day limits in ID# F-1, Column G, and the episode limits in ID# F-1, Column H.

Instructions

As discussed, the managed care plan should indicate the type of QTL ***that applies to MH/SUD benefits*** in ID# F-1. For example, the managed care plan should indicate "day limits" in ID# F-1, Column G, if there are day limits that apply to MH/SUD benefits – within a benefit package(s) and benefit classification. Note that QTLs are numerical limitations on benefits or services that ***cannot be exceeded by medical necessity criteria***; in other words, there is no process by which the entity providing benefits (i.e., managed care plan) can exceed the numerical limitation. If the managed care plan can exceed the numerical limitation using medical necessity criteria or some other process, this would be an NQTL.[19]

In ID# F-2, the managed care plan should then describe the level or magnitude of the QTL indicated in ID# F-1. 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# F-2, the managed care plan should also describe

[19] See Identifying and Analyzing Non-Quantitative Treatment Limitations (NQTLs). Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs at p. 34.

for which type of services (in the prior example, SUD residential treatment) the QTL is applied within the classification.

The next two questions (IDs# F-3-4) are intended to streamline the managed care plan's parity documentation, if applicable. If the managed care plan provides both MH/SUD and M/S benefits and can attest in ID# F-3 that the type of 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 the managed care plan provides a description of how this is the case in ID# F-4 – the managed care plan does not need to answer the remaining questions in the set (IDs# F-5-11).[20]

If the managed care plan cannot attest that the type of 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 if the managed care plan is not able to provide a description of how this is the case, the managed care plan should complete the remaining questions in the set (IDs# F-5-11), as applicable.

In ID# F-5, if a managed care plan provides M/S benefits, the managed care plan should record the results of its cost analysis to indicate the total dollar amount of expected payments for all M/S benefits subject to the QTL in a contract year (ID# F-5) and the total dollar amount of expected payments for all M/S benefits in a contract year (ID# F-6). The managed care plan should attach its detailed cost analysis with the Reporting Template upon submission. The percentage (included as a formula in ID# F-7) is the calculation of the amount indicated in ID# F-5 divided by the amount indicated in ID# F-6. If the managed care plan cannot provide a cost analysis in IDs# F-5-7, it should explain why the cost analysis was not completed in ID# F-8 and report this information to the State.

ID# F-9: If the percentage in ID# F-7 is less than 66.7%, the QTL cannot be applied to MH/SUD benefits in the benefit classification per Federal parity requirements.[21] The managed care plan should explain why the QTL is still applied despite not meeting these requirements and report it to the State using the "AE_Issues for Discussion" worksheet.

IDs# F-10-11: If the percentage in ID# F-7 is 66.7% or greater, the managed care plan should enter the predominant level of the QTL in ID# F-10. The predominant level is either the single level of the QTL (e.g., 90-day limit) that applies to more than half (50%) of M/S benefits in the classification that are subject to that 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 the classification that are subject to that type of QTL. For the predominant level provided in response to ID# F-10, the managed care plan should indicate using the drop-down options for the response to ID# F-11 if it used a single level of the QTL that applies to more than 50% of all M/S benefits subject to that

[20] See Analysis of Financial Requirements, Quantitative Treatment Limitations, and Aggregate Lifetime and Annual Dollar Limits, Tip 5a in Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs at p. 22.

[21] 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) for Medicaid managed care, CHIP, and ABP, respectively.

QTL ("Single Level") or if it used the least restrictive of a combination of levels of the QTL used to reach 50% of all M/S benefits subject to that QTL ("Least Restrictive within Combination of Levels").[22] If the managed care plan applies a level of the QTL ***to MH/SUD benefits*** that is more restrictive than this predominant level of QTL,[23] the managed care plan should report it to the State using the "AE_Issues for Discussion" worksheet.

Figure 6 below demonstrates an example of a QTL applied to MH/SUD benefits. The cost analysis in ID# F-7 is greater than 66.7%, so the managed care plan indicates the predominant level and selects "Least Restrictive within Combination of Levels" to indicate that levels of the QTL were combined to reach 50% of all M/S benefits and that the least restrictive level within the combination was applied to MH/SUD benefits.

Figure 6: Sample "F_QTL" Worksheet – Day Limit for one Benefit Package

F. Quantitative Treatment Limitations

This section relates to FRs applied to benefits delivered to enrollees of Medicaid managed care plans in accordance with 42 CFR § 438.910(a)-(c), benefits delivered to CHIP enrollees in accordance with 42 CFR benefits delivered to enrollees of Medicaid ABPs in accordance with 42 CFR § 440.395(b). Refer to Instructional Guide for more detailed instructions.

ID#	Benefit Package	Benefit Classificatio	Question	Response Type	Response
F-1	Benefit Package B	Outpatient	If the managed care plan provides MH/SUD benefits, indicate the type of quantitative treatment limit (QTL) (e.g., hour limit, day limit, waiting period) that applies to MH/SUD benefits in this classification using the applicable column(s).	Free Text	Day limit
F-2	Benefit Package B	Outpatient	If the managed care plan provides MH/SUD benefits, describe the level (i.e., magnitude) of QTL (e.g., 5 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	90-day limit on SUD residential treatment
F-3	Benefit Package B	Outpatient	If the managed care plan provides M/S and MH/SUD benefits, 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
F-4	Benefit Package B	Outpatient	If Yes to #3 and if the managed care plan provides M/S and MH/SUD benefits, 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	
F-5	Benefit Package B	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for M/S benefits in this classification subject to the QTL in a contract or plan year?	Number	$3,500,000.00
F-6	Benefit Package B	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for all M/S benefits in this classification in a contract or plan year?	Number	$5,000,000.00
F-7	Benefit Package B	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the percentage of all expected payments for all M/S benefits subject to the QTL in this classification in a contract or plan year?	Percentage Auto-calculated Field	70.00%
F-8	Benefit Package B	Outpatient	If No to #3 and if the managed care plan provides M/S benefits and did not complete a cost analysis, explain why this was not completed to satisfy requirements at 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) and report it to the State in the Issues for Discussion worksheet.	Free Text	NA
F-9	Benefit Package B	Outpatient	If the percentage in #7 is less than 66.7% and if the managed care plan provides M/S and MH/SUD benefits, explain why the limit is still applied despite not meeting the requirements at 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) and report it to the State in the Issues for Discussion worksheet.	Free Text	NA
F-10	Benefit Package B	Outpatient	If the percentage in #7 is 66.7% or greater and if the managed care plan provides M/S benefits, 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 of the QTL used to reach 50% of M/S benefits in the classification subject to this type of QTL.	Free Text	90-day
F-11	Benefit Package B	Outpatient	Is the predominant level in #10 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? If the predominant level in #10 is neither a single level nor the least restrictive level within a combination of levels of the QTL based on requirements at 42 CFR § 438.910(c)(1)(ii), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i), report it to the State in the Issues for Discussion worksheet.	Dropdown	Least Restrictive Level within Combination of Levels

Nonquantitative Treatment Limitations

Regulatory basis for the section

Medicaid managed care: 42 CFR § 438.910(d)

[22] See footnote 16 on p. 17.
[23] See footnote 16 on p. 17.

CHIP: 42 CFR § 457.496(d)(4)

ABP: 42 CFR § 440.395(b)(4)

Overall Layout

If applicable, the managed care plan completes worksheets corresponding to the five prioritized NQTLs prepopulated within the Reporting Template for each of the four benefit classifications (i.e., inpatient, outpatient, emergency care, and prescription drugs). These NQTLs are as follows:

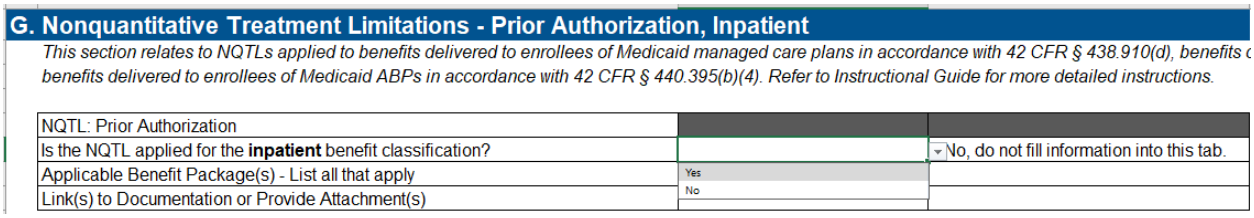
1. Prior Authorization
2. Concurrent Review
3. Step Therapy/Fail First
4. Standards for Provider Network Admission *(only required for managed care plans establishing a provider network, separate from the FFS network)*
5. Standards for Access to Out-of-Network (OON) Providers *(only required for managed care plans establishing a provider network, separate from the FFS network)*

There are an additional four NQTL worksheets, which are not prepopulated with NQTLs; a managed care plan may use these worksheets to report any other type of NQTL. Each of the NQTL worksheets contain preliminary informational questions followed by questions that require comprehensive, detailed responses regarding the strategies, evidentiary standards, processes, and other factors considered in the design and used in the application of the respective NQTLs.

Instructions

The top of each NQTL worksheet contains a series of preliminary questions. In Column C, the managed care plan should first select from drop-down options whether the specified NQTL is applied by the managed care plan within the benefit classification specified in the worksheet. ***If the managed care plan selects "No" that the NQTL is not applied within the specified benefit classification, no further information should be entered, and the managed care plan should move to the next worksheet***.

Figure 7: NQTL Preliminary Questions



If the managed care plan applies the NQTL to the specified benefit classification, it should then:

- List all benefit package(s) to which the managed care plan applies the NQTL. If the managed care plan applies the NQTL to all benefit packages listed on the "B_Managed Care Plan Data" worksheet, then the managed care plan may enter "All."

- Include any available links or attachments to documentation (e.g., utilization management policies) that provide further detail on the NQTL.

The preliminary questions for the four "Other" NQTL worksheets differ slightly, given that the NQTL name and the benefit classification are not prepopulated. In the "Other" NQTL worksheets, the managed care plan should enter the name of the NQTL and choose the benefit classification within which the NQTL is applied from the drop-down options.

Once the preliminary questions have been answered, and if the NQTL is applied within the benefit classification, the managed care plan should provide a detailed NQTL analysis. This analysis includes five questions to which the managed care plan should respond to describe its application of the NQTL. These five questions are the same for all NQTL worksheets. There are separate data entry fields for the managed care plan to describe its application of the NQTL to MH/SUD and M/S benefits, respectively. If the managed care plan does not offer MH/SUD or M/S benefits, then the managed care plan should indicate "Not Applicable" in the respective data entry fields.

For each of the five questions of the NQTL analysis, as described below, the managed care plan should assess the information at the benefit package level. If the NQTL as written and in operation is applied identically using the same strategies, evidentiary standards, processes, and/or other factors for MH/SUD benefits in all benefit packages and using the same strategies, evidentiary standards, processes, and/or other factors for M/S benefits in all benefit packages, ***the managed care plan only needs to provide the information once for all benefit packages in which the NQTL is written and applied identically for M/S benefits, and is written and applied identically for M/S benefits.*** If there are differences in strategies, evidentiary standards, processes, and/or other factors by benefit package, the managed care plan should use the appropriate columns across the top of the table (i.e., MH/SUD – Benefit Package 1, M/S – Benefit Package 1, MH/SUD – Benefit Package 2, M/S – Benefit Package 2, and so on) to indicate such differences by benefit package.

The managed care plan should answer five questions in its analysis:

- **List the benefits to which the NQTL applies**
    - The managed care plan should provide a list of all benefits within the benefit classification to which the NQTL is applied.
- **Strategies: What are the strategies that the managed care plan used to design the NQTL, as written and in operation? If strategies are different by benefit package, specify the information about strategies by benefit package using the appropriate columns.**
    - The managed care plan should describe all strategies that it considers, reviews, or uses to design the NQTL within the benefit classification.
    - Examples of strategies that the managed care plan may consider describing include, but are not limited to:
        - Treatment guidelines or guidelines provided by third-party organizations;

        - Rationales for threshold amounts, professional standards, and fee schedules;
        - Breadth of sources and evidence considered;
        - Consultations with panels of experts in designing the NQTL.
- **Evidentiary Standards: What evidentiary standards did the managed care plan consider or rely upon to design a factor with respect to the NQTL, including specific benchmarks or thresholds? If evidentiary standards are different by benefit package, specify the information about evidentiary standards by benefit package using the appropriate columns.**
    - The managed care plan should describe any evidence, sources or standards that it considered or relied upon to design or apply a factor for the NQTL within the benefit classification.
    - Examples of evidentiary standards that the managed care plan may consider describing include, but are not limited to:
        - Objective third party sources;
        - Internal managed care plan data;
        - Benchmarks or thresholds.
- **Processes: What are the processes that the managed care plan applies to the NQTL, as written and in operation? If processes are different by benefit package, specify the information about processes by benefit package using the appropriate columns.**
    - The managed care plan should describe any actions, steps, or procedures that it uses to apply the NQTL within the benefit classification.
    - Examples of processes that the managed care plan may consider describing include, but are not limited to:
        - Procedures to submit information;
        - Provider referral requirements;
        - Staff procedures to administer the application of NQTLs.
- **Other Factors: What factors not already addressed in the processes or strategies questions above did the managed care plan consider or rely upon to design the NQTL, or to determine how the NQTL applies to benefits under the benefit package(s)? If other factors are different by benefit package, specify the information about other factors by benefit package using the appropriate columns.**
    - This question provides managed care plans an opportunity to describe any other factors not described elsewhere in the comparable analysis.
    - If no additional factors are considered or relied upon to design or apply the NQTL within the benefit classification, the managed care plan should enter "Not Applicable."

Issues for Discussion

Overall Layout

The "AE_Issues for Discussion" worksheet summarizes the managed care plan's identified issues that may require discussion across all worksheets in this Reporting Template. States may use the below process for collecting and reviewing issues for discussion with their managed care plans.

IMPORTANT: In the "AE_Issues for Discussion" worksheet:

- The managed care plan cannot delete rows. Resolved issues for discussion will remain in the worksheet, with the "Issue Resolved-ACTUAL Date" identified.
- The managed care plan 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.

Instructions

The following describes the steps a managed care plan should take in filling out the "AE_Issues for Discussion" worksheet under three scenarios: New Entry, Update Existing Entry, and No Changes.

Scenario 1: New Entry

Step 1: The managed care plan identifies a new issue for discussion based on information provided in this Reporting Template. The managed care plan should navigate to the "AE_Issues for Discussion worksheet" and complete the following fields:

- **ID Number Column (Column B)**
  - This field is prepopulated. No action from the managed care plan is necessary.
- **Entry Type Column (Column C)**
  - The managed care plan 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 D)**
  - The managed care plan should indicate the relevant benefit package(s) to which this issue for discussion applies.
- **Relevant Reporting Template Section Column (Column E)**
  - The managed care plan should select from the drop-down options to indicate the relevant Reporting Template section.
- **Relevant Benefit Classification(s) Column (Column F)**
  - The managed care plan 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 managed care plan to select a single benefit classification. If an issue impacts multiple benefit classifications, the managed care plan should enter an additional issue for discussion in a subsequent row.
- **Description of Issue for Discussion Column (Column G)**

- The managed care plan should provide a description of the issue for discussion, including the current date (MM/DD/YYYY) prior to the free text.

- **Does the Issue for Discussion relate to Operations, Documentation, or Both? Column (Column H)**
  - The managed care plan 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 managed care plan should provide a description of past and/or future action(s) addressing the issue for discussion, including interactions with the State and/or CMS; other involved stakeholders; and any State laws, regulations, or policies that require a change. When making entries to this field, the managed care plan should include a date (MM/DD/YYYY) prior to the free text.
- **Issue Resolved- EXPECTED Date Column (Column J)**
  - The managed care plan should provide the date it expects the issue to be resolved, in the format MM/DD/YYYY.
- **Issue Resolved- ACTUAL Date Column (Column K)**
  - The managed care plan should provide the actual date the issue was resolved, in the format MM/DD/YYYY. If the issue is not yet resolved, the managed care plan should leave this field blank.

Figure 8 below provides an example of a new issue for discussion entry.

Figure 8: Sample "AE_Issues for Discussion" Worksheet – New issue for discussion entry

AE. Issues for Discussion

Refer to Instructional Guide for detailed instructions.

ID Number	Entry Type (New, Update, No Changes)	Relevant Benefit Package(s)	Relevant Reporting Template Section	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
AE-1	New	Benefit Package X	FR	Outpatient	FR is applied to less than 66.7% of all M/S benefits in the classification, but is being applied to MH/SUD benefits in the classificaton.	Both	10/30/2024 - Managed care plan identified the issue through parity analysis and is working with the State to address its operations and policy.	6/30/2025	

Step 2: The managed care plan should navigate back to the relevant worksheet where it identified the issue for discussion and add the ID number (found in column B in the "AE_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 managed care plan identified an issue for discussion in the "E_FR" worksheet, the managed care plan should enter information about this issue in the "AE_Issues for Discussion" worksheet using the first available row (for example, ID# AE-1). The managed care plan should then indicate in the relevant cell in the "E_FR" worksheet the corresponding ID number (i.e., ID# AE-1) from the "AE_Issues for Discussion" worksheet. Figure 9 below provides an example to demonstrate this.

Figure 9: Sample "AE_Issues for Discussion" Worksheet – Adding an Issue ID Number

E. Financial Requirements

This section relates to FRs applied to benefits delivered to enrollees of Medicaid managed care plans in accordance with 42 CFR § 438.910(a)-(c), benefits delivered to CHIP enrollees in accordanc benefits delivered to enrollees of Medicaid ABPs in accordance with 42 CFR § 440.395(b). Refer to Instructional Guide for more detailed instructions.

ID#	Benefit Package	Benefit Classificati	Question	Response Type	Response
E-1	Benefit Package Z	Outpatient	If the managed care plan provides MH/SUD benefits, 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
E-2	Benefit Package Z	Outpatient	If the managed care plan provides MH/SUD benefits, 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 for primary care visit
E-3	Benefit Package Z	Outpatient	If the managed care plan provides M/S and MH/SUD benefits, 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
E-4	Benefit Package Z	Outpatient	If Yes to #3 and if the managed care plan provides M/S and MH/SUD benefits, 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	
E-5	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for M/S benefits in this classification subject to the FR in a contract year?	Number	$3,000,000.00
E-6	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the total dollar amount of expected payments for all M/S benefits in this classification in a contract year?	Number	$10,000,000.00
E-7	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits, what is the percentage of all expected payments for all M/S benefits subject to the FR in this classification in a contract year?	Percentage. Auto-calculated Field	30.00%
E-8	Benefit Package Z	Outpatient	If No to #3 and if the managed care plan provides M/S benefits and did not complete a cost analysis, explain why this was not completed to satisfy requirements at 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) and report it to the State in the Issues for Discussion worksheet.	Free Text	NA
E-9	Benefit Package Z	Outpatient	If the percentage in #7 is less than 66.7% and if the managed care plan provides M/S and MH/SUD benefits, explain why the limit is still applied despite not meeting the requirements at 42 CFR § 438.910(c)(1)(i), 42 CFR § 457.496(d)(3)(i), and 42 CFR § 440.395(b)(3)(i) and report it to the State in the Issues for Discussion worksheet.	Free Text	Copayment is still applied to MH/SUD benefits. Issue for Discussion **ID Number AE-1**

Scenario 2: Update Existing Entry

Step 1: The managed care plan identifies an ***update*** to an ***existing*** issue for discussion entry (ID Number and entry already exist in the "AE_Issues for Discussion" worksheet). The managed care plan should navigate to the "AE_Issues for Discussion" worksheet and provide updates to the following fields, if applicable:

- **ID Number Column (Column B)**
  - This field will be auto-populated and *does not change*. No action from the managed care plan 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 C)**
  - The managed care plan 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 D)**

- If necessary, the managed care plan should update the name of the relevant benefit package(s) to which this issue for discussion applies. If there is no update, the managed care plan should not change information in this field.

- **Relevant Reporting Template Section Column (Column E)**
  - If necessary, the managed care plan should update the selection of the relevant Reporting Template section to which this issue for discussion applies. If there is no update, the managed care plan should not change information in this field.
- **Relevant Benefit Classification(s) Column (Column F)**
  - If necessary, the managed care plan should update the relevant benefit classification to which this issue for discussion applies. If there is no update, the managed care plan should not change information in this field.
- **Description of Issue for Discussion Column (Column G)**
  - If necessary, the managed care plan should update the description of the issue for discussion. The managed care plan should keep the existing description and provide the current date (MM/DD/YYYY) next to the updated description. The update history should descend from most recent to least recent. If there is no update, the managed care plan should not change information in this field.
- **Does the Issue for Discussion relate to Operations, Documentation, or Both? Column (Column H)**
  - If necessary, the managed care plan should update this field by selecting from the drop-down options, as described below. If there is no update, the managed care plan 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 managed care plan should provide an update to the existing description of past and/or future action(s) addressing the issue for discussion, including interactions with the State and/or CMS; other involved stakeholders, and any State laws, regulations, or policies that require a change. The managed care plan should explain updated information. If there is a change to the "Issue Resolved- EXPECTED DATE," the managed care plan should explain why the date has changed. If there is a change to the "Issue Resolved- ACTUAL Date," the managed care plan should explain how the issue was resolved.
    - When making entries to this field, whether new or updated entries, the managed care plan 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 least recent.

- **Issue Resolved- EXPECTED Date Column (Column J)**
  - If the expected date of resolution has changed, the managed care plan 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 managed care plan should provide the actual date the issue was resolved, in the format MM/DD/YYYY.

Step 2: The managed care plan should only complete this step if the existing issue for discussion is now resolved. If the issue is now resolved, the managed care plan 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. This is the final step in updating the issue for discussion.

Scenario 3: No Changes

Step 1: If the managed care plan is submitting updated parity documentation (i.e., an updated Reporting Template), the managed care plan should navigate to the "AE_Issues for Discussion" worksheet. For each existing issue for discussion for which there is no update in this submission, the managed care plan should change the following field only:

- **Entry Type (Column C)**
  - The managed care plan 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 managed care plan is necessary.

Conclusion

The Reporting Template and this accompanying Guide are intended to support States, and the managed care plans with whom they contract, in ensuring compliance with Federal parity requirements through improved documentation. MHPAEA and related Medicaid and CHIP regulations[24] apply MH and SUD parity protections to coverage provided to enrollees of Medicaid MCOs, Medicaid ABPs, and CHIPs. These protections help to ensure that enrollees can access MH and SUD benefits at parity with access to M/S benefits. If further information is needed regarding this Reporting Template and Guide, please contact State Medicaid and/or CHIP staff.

[24] See footnote 2 on pg. 3.