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

September 2024

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[1] All acronyms will be defined prior to their first use in the Instructional Guide.

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[2] See footnote 1 on page 1

Background

The purpose of this Instructional Guide for Mental Health and Substance Use Disorder Parity State Summary Template (Guide) is to support States, as well as the entities that provide Medicaid benefits to Medicaid managed care organization (MCO) and/or Alternative Benefit Plan (ABP) enrollees and the entities that provide Children's Health Insurance Program (CHIP) benefits to CHIP enrollees, in documenting compliance with mental health (MH) and substance use disorder (SUD) parity requirements to the Centers for Medicare & Medicaid Services (CMS).[3] This Guide, the accompanying Mental Health and Substance Use Disorder Parity State Summary Template (Template), and the Mental Health and Substance Use Disorder Parity Managed Care Plan[4]/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, MCOs, and CMS.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related Medicaid and CHIP regulations[5] apply MH and SUD parity protections to coverage provided to enrollees of Medicaid MCOs[6] and coverage provided by Medicaid ABPs and CHIP. 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 aim to provide a primer on MHPAEA requirements' applicability to Medicaid and CHIP. To assist States with implementing parity requirements, CMS previously issued a detailed Parity Compliance Toolkit, a Parity Implementation Roadmap, Frequently Asked Questions and hosted several webinars.[7] CMS also provides individualized technical assistance to States on an ongoing basis.

On September 29, 2023, CMS issued a Request for Comments (RFC) on processes for assessing parity compliance.[8] In response, there was general consensus among stakeholders, including

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[3] References to CMS in this Guide and the accompanying State Summary 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.

[4] "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).

[5] 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" is used to refer to these mental health and substance use disorder parity requirements, unless otherwise noted.

[6] 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.

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

[8] *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).

those representing States, MCOs, and advocates, for CMS to provide standardized templates to improve the effectiveness of States' documentation of parity compliance and the review of such documentation by CMS.

On June 12, 2024, CMS issued a CMCS Informational Bulletin (CIB)[9] that reiterated CMS' expectations for the submission of Medicaid managed care and CHIP parity compliance documentation to CMS. The June 12, 2024, CIB also highlights concerns raised by a recent report[10] from the U.S. Department of Health and Human Services Office of Inspector General (OIG) regarding a sample of States not complying with Federal parity requirements for Medicaid MCO enrollees. Out of a sample of eight States, the OIG found that five States and their MCOs did not conduct required parity analyses by the compliance date established in CMS' regulations, and none of the 8 States made documentation of compliance available to the public by the compliance date. In addition, all 8 of the selected States may not have ensured that all services were delivered to MCO enrollees in compliance with parity requirements. The OIG report recommended that CMS improve its oversight of States' compliance with Federal parity requirements to support States in their oversight of Medicaid managed care compliance with parity requirements for MCO enrollees.

In response to the recent OIG report and stakeholder recommendations from the RFC, CMS has developed this Guide, the accompanying Template, and the Mental Health and Substance Use Disorder Parity Plan/State FFS Reporting Template and its corresponding guide. 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, MCOs, and CMS. Importantly, these templates and guides support the overall objective that enrollees in need of MH and/or SUD services can access such services at parity with access to medical and surgical (M/S) services.

[9] 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).

[10] 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).

Overview of Template Sections

The Template includes sections for 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 sections that correspond to the Federal parity requirements 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 sections of the Template are prepopulated with a non-exhaustive prioritized list of five NQTLs. In each NQTL worksheet, for the entity(ies) delivering the benefit packages offered to enrollees in each program type (MCO, CHIP, ABP) in the State that applies the NQTL, the State should comprehensively document how the NQTL is applied. The non-exhaustive prioritized list of five NQTLs is below:

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 NQTL sections include additional tables for the State to list additional NQTLs that entities operating in the State apply to enrollees in each program type (MCO, CHIP, or ABP).

There are a significant number of worksheets incorporated in this Template with the goal of ensuring consistency and reducing duplication across Medicaid managed care, CHIP, and ABP program types. Sections that correspond with the Federal parity requirements regarding financial requirements and treatment limitations are structured in separate worksheets by program type: Medicaid MCO (in the Template worksheets referred to as "MCO"), Separate CHIP (in the Template worksheets referred to as "CHIP"), and ABP. The State should enter information in these respective sections as follows:

- The State should use the MCO worksheets in this Template for all benefits delivered to Medicaid MCO enrollees regardless of delivery system, including both non-ABP and ABP benefit packages if delivered through a Medicaid MCO.
- The State should use the CHIP worksheets in this Template for separate CHIP benefit packages, regardless of delivery system. If the CHIP benefit package is a Medicaid expansion CHIP or combination CHIP benefit package, States should use the MCO worksheets.

- The State should use the ABP worksheets in this Template for ABP benefit packages delivered through FFS, including benefit packages delivered through FFS with one or more benefits delivered through either a PIHP or PAHP.

The State should, as applicable, complete the parity analysis at the benefit package level within each program type (Medicaid MCO, CHIP, or ABP).[11] As described in detail later in this Guide, the Template is structured to avoid duplication of data entry where possible, such as when the application of NQTLs is identical across benefit packages and/or program types.

Due to the separation by 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 following subsections of this Guide will describe each worksheet's structure, purpose, and detailed instructions for completing the Template.

- 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 Parity Analysis (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 Parity Analysis (6 worksheets)[13]
  - "P_All Limits-CHIP"
  - "Q_FR-CHIP"
  - "R_QTL-CHIP"
  - "S_Intro NQTL-CHIP"
  - "T_NQTL-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.

  - "U_Issues for Discussion-CHIP"
- ABP Parity Analysis (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 of the worksheets include functionality that prevents users from reporting the same data more than once. For example, the State must enter benefit package information in the "Program Type Data" worksheets; these entries then auto-populate 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; therefore, users cannot edit such fields.

Important Excel User Tips:

1. **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.***

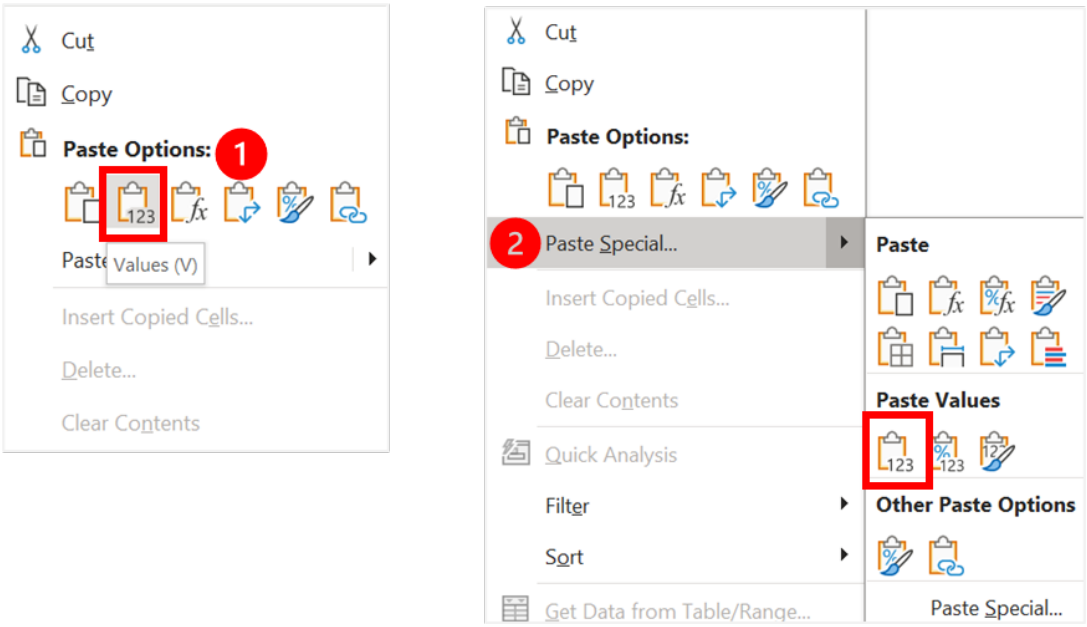
How to copy/paste values or texts only.

- **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.**

See example in Figure 1.

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

Figure 1: Excel User Tips - Selecting "Paste Values"



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.

2. **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.

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. The detailed instructions for individual worksheets also explain, where applicable, how the State may avoid potential duplication of information across benefit packages and program types (e.g., when an entity applies NQTLs identically in both the CHIP and MCO program types) to reduce administrative burden. 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) in the Medicaid and CHIP Operations Group (MCOG).

Detailed Instructions for Individual Worksheets

While the Template is organized into a Medicaid MCO Parity Analysis (defined as "MCO" in the Template), a CHIP Parity Analysis, and an ABP Parity Analysis, each of which contain identical worksheets (except for nuances related to the application of AL-ADLs), this Guide is organized topically. Therefore, the Guide includes a description of the topical worksheets (e.g., Program type Data, FR, QTL, NQTL, Issues for Discussion), and the State should follow these instructions when completing the applicable worksheet(s) regardless of whether it is part of a Medicaid MCO Parity Analysis, CHIP Parity Analysis, or ABP Parity Analysis.

Instructions

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

Introduction Data

Overall Layout and Instructions

In this worksheet ("B_Intro Data"), the State should provide contact information for the State staff responsible for the completion and submission of the Template. If there are multiple points of contact, please enter all appropriate contact information within the same field, with information for distinct contacts clearly separated (e.g., with a semi-colon or comma). Include necessary information regarding who CMS should contact in parentheses (e.g., if one contact is for CHIPs and one is for ABPs that should be clearly denoted in parentheses after the respective contact information). Required data elements and their descriptions 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 the following:

- **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, 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 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]

▪ ABP:

- When there is a new ABP State Plan Amendment (SPA) to implement an ABP delivered through FFS.[19]
- When there is an amendment to an approved ABP that is 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.[20]
- 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.

- **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 "Updated submission" if this is an updated version of a prior submission if the State has previously submitted parity documentation to CMCS on this Template. The State should select "New submission" if the State

[15] See 42 CFR §438.3(n)(2).
[16] See footnote 9 on p. 4
[17] See footnote 11 on p. 6.
[18] See footnote 11 on p. 6.
[19] 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.
[20] 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.

has never submitted parity documentation to CMCS or if the State has submitted parity documentation to CMCS but not 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 one NQTL, the State would indicate that the change relates to this formerly identified "Issue for Discussion" in the NQTL section.

The remaining table in this section, 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.

Program Type Data (MCO, CHIP, ABP)

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 benefits within those benefit packages for MH, SUD, and M/S benefits. Medicaid MCO benefit package(s), including ABP benefit packages in which one or more benefits are delivered through a Medicaid MCO, should be included in the "C_MCO Program Data" worksheet. Separate CHIP benefit package(s) should be included in the "D_CHIP Program Type Data" worksheet. Only ABP benefit package(s) delivered through FFS, or ABP benefit package(s) delivered through a combination of FFS and a PIHP and/or PAHP should be included in the "E_ABP Program Type Data" worksheet.

Instructions

Step 1: Program Type Overview

- Identify all benefit packages to which parity applies on separate rows.
    - A benefit package includes all 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.[21]

[21] 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*. Section 2.2, p. 9. Located at Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs

  - 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[22]; 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 2.

Figure 2: Example Step 1 from Program Type Overview Worksheets

: **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	All benefits delivered by single 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

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 or

[22] 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.

more benefits delivered through a Medicaid MCO have been appropriately identified and entered within the Template.

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.

"E_ABP Program Type Data" includes a sub-step Step E-1A that 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.

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 benefits for each category of conditions (MH, SUD, and M/S).
    - 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 managed care and FFS delivery systems are used within one category of conditions (MH, SUD, and M/S), use a separate row per delivery system to indicate which entities provide benefits within that category of conditions.
        - For example, if preventative MH benefits are delivered through managed care and specialty MH benefits are delivered through FFS, use two rows to indicate the entities that provide those benefits in the benefit package. An example of how these entities should be entered in Step 2 is shown in Figure 3. Notes/Comments in column H should summarize which benefits in that category are provided through which delivery system.

Figure 3: Example Step 2 from Program Type Overview worksheets with benefits delivered through multiple entities

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

Refer to Instructional Guide for detailed instructions.						
Auto-populated		*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 differen entities**
1-MCO	Benefit Package 1-MCO	MCO A	MCO A	MCO A	Preventive MH/SUD delivered by MCO	Y
2-MCO	Benefit Package 1-MCO	State FFS	State FFS	MCO A	Acute MH/SUD delivered through FFS	Y

- Enter any notes or comments in the Notes/Comments Column (Column H).
    - This column should be used to clarify complexities regarding the way in which benefits are delivered in the benefit package. As noted, when multiple entities or delivery systems provide benefits for a category of conditions within a benefit package (such as in Figure 2), the Notes/Comments should summarize which benefits are provided by which entity or under which delivery system. Furthermore, if a listed entity (e.g., an MCO) utilizes a vendor or subcontractor to deliver certain benefits, that arrangement should be described in the Notes/Comments Column.
- The Calculated Field Column (Column I) in Step 2 is an auto-calculated column and ***no action is needed by the State in this column***. The calculation indicates if MH and SUD are provided by the same entity or not. This logic feeds into the "Intro NQTL" worksheets. When MH and SUD are provided by the same entity, Column I will show "Y." ***Please note, the names of the Entity Providing Benefits need to be entered exactly the same (e.g., no extra spaces, same capitalization) for this logic 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 4). In these instances, the State should double-check to ensure the entities providing MH and SUD are, in fact, different.

Figure 4: 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.						
Auto-populated		*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	Preventive MH/SUD delivered by MCO	Y
2-MCO	Benefit Package 1-MCO	State FFS	State FFS	MCO A	Acute MH/SUD delivered through FFS	Y
3-MCO	Benefit Package 2-MCO	Aetna	Aetna	Aetna		Y
4-MCO	Benefit Package 2-MCO	Blue Cross	Blue**C**ross	Blue Cross		**N**
5-MCO	Benefit Package 3-MCO	MCO B	MCO B	MCO B		Y
6-MCO	Benefit Package 3-MCO	MCO B	MCO B	State FFS	Long-term services and supports delivered through FFS	Y

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 section includes six questions.

- ID# F-1**:** The State should list all information sources that were 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, they 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 section, if necessary to resolve questions during CMS' review of the Template.

- ID# F-2**:** The State should provide an explanation of how it gathered the information reviewed for the Template.

  For example, this could include a description of the optional 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 any source documentation that the State required to perform its analysis.

- ID# F-3**:** The State should provide a brief description of the benefit packages that it offers and that are analyzed within the Template.

  This question is seeking a brief narrative overview of the benefit packages and delivery systems used by States. While separate worksheets within the template will capture detailed information about the entities that provide benefits (i.e., managed care plans or State FFS), this field should be used to describe any noteworthy information about the entities and delivery systems that would provide helpful context for the analysis (e.g., the structure and extent of any benefits that are not included in an MCO's contract and are provided using another delivery system or through a different managed care plan).

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

  If the answer is yes, the State should provide a description of the issue(s) and what step(s)/strategy(ies) the State took to resolve or mitigate the issue(s) or challenge(s). 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 submission provides a point-in-time assessment of parity compliance. In its 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 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.

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.

Definitions of MH-SUD and MS

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[23]. It also requires the State to define the four benefit classifications: inpatient, outpatient, emergency care, and prescription drugs[24]. 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 the 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 the standard deviates from the ICD.
- IDs# G-3-4: the State should enter its MH definition. The drop-down options for ID# G-3 are: International Classification of Diseases (ICD); Diagnostic and Statistical Manual of Mental Disorders (DSM); or Other. The State should only select "ICD" or "DSM" if the guidelines are 100% aligned with those in the ICD or DSM as applicable. Otherwise, it should select "Other" in ID# G-3 and explain in ID# G-4 how the standard deviates 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 as applicable.

[23] See section 3, Defining Mental Health and Substance Use Disorder (MH/SUD) Benefits in Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, p. 10-15

[24] See section 4, Defining Classifications and Mapping Benefits to Classifications in Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, p. 16-20

Otherwise, it should select "Other" in ID# G-5 and explain in ID# G-6 how the standard deviates 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 respectively. IDs# G-7-10 are free-text cells with no drop-down response options.

Figure 5: Example Definitions MH-SUD MS worksheet

G. State's Definitions of M/S, MH, and SUD			
Refer to Instructional Guide for more detailed instructions.			
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	

Benefit Classification Mapping

Overall Layout and Instructions

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

- The Benefit Column (Column A) has free-text cells where the State should enter each benefit covered in the benefit packages that are included in the Template.
- The Condition (MH/SUD or M/S) Column (Column B) includes two drop-down options (M/S or MH/SUD) where the State indicates if the benefit listed is a M/S or MH/SUD benefit.
- The Benefit Classification(s) Column (Column C) includes four drop-down options (Inpatient, Outpatient, Emergency Care, Prescription Drugs) for the State to indicate the benefit's classification.
- Column D only applies to benefits that are included in ABPs and requires the State to indicate if the benefit listed in Column A is an essential health benefit (EHB) or an "Other 1937" service. The drop-down options for Column D are: "EHB"; "Other 1937"; or NA. ***If any ABP benefit packages appear in Columns E-X, the State should select "Yes" or "No" in Column D. If none of the benefit packages in columns E-X are an ABP, the State will select "NA" in Column D***.

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

- Columns E-X require the State to indicate to which benefit packages the benefits in the Benefit Column (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-X) to indicate if the benefit in the Benefit Column (Column A) is covered in the applicable benefit package.

Figure 6 provides an example of how a State would list the Acupuncture and Ambulatory Detoxification benefits assuming the former is a M/S benefit and the latter a MH/SUD benefit in the outpatient 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

H. Benefit Classification Mapping

Refer to Instructional

Identify the benefit.	*Indicate if the benefit is MH/SUD or M/S.*	*Select the benefit classification from the drop-down options.*		*Is the benefit in Column A covered in the benefit package below? Choose from dropdown (Yes/No)*	*Is the benefit in Column A covered in the benefit package below? Choose from dropdown (Yes/No)*
Benefit	**Condition (MH/SUD or M/S)**	**Benefit Classification(s)**	**For benefits included in an ABP, indicate if benefit 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

All Limits (Medicaid MCO, CHIP, ABP)

Overall Layout and Instructions

The All Limits worksheets ("I_All Limits-MCO," "P_All-Limits-CHIP," and "V_All Limits-ABP") include a series of 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 the inclusion of ALs or ADLs.[25] 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) in the State. However, each question is asking whether an AL or ADL, FR, QTL, or NQTL, respectively, is

[25] 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. 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).

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.

- In IDs# 1-2 of the "I_All Limits-MCO"[26] 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, the State 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), the State 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.[27] 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, the State should not complete the corresponding "K_FR-MCO," "Q_FR-CHIP," and/or "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

[26] 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.

[27] 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.

worksheets ("O_Issues for Discussion-MCO," "U_Issues for Discussion-CHIP", or "AA_Issues for Discussion-ABP"). See Figure 7 for an example of how the special rule is incorporated into the worksheets.

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

I. Financial Requirements and Treatment Limitations - MCO

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

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		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		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 into the Template 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 as shown in Figure 8, the J_AL-ADL-MCO worksheet will turn gray as shown in Figure 8, and a message will appear in the top row to indicate that the State should "SKIP THIS TAB".

Figure 8: Appearance of AL-ADL worksheet if State All-Limits worksheet indicates no AL-ADLs

J. Aggregate Lifetime Dollar Limits and Annual Dollar Limits - MCO ***SKIP THIS TAB 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 for more detailed instructions.

Question ID	Benefit Package	Entity Providing MH/SUD Benefits	Entity Providing M/S Benefits	Question	Response Type	Response	Response2
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		
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)		
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		
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	All	All	Describe the aggregate lifetime dollar limit (AL) or annual dollar limit (ADL) applied to MH/SUD benefits.	Free Text		
J-2	Benefit Package 2-MCO			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)		

If the State answers "Yes' to ID#s 4-6 related to the Special Rule for any program type, the corresponding FR worksheets will also turn gray in their entirety.

If a State applies one or multiple of the five prioritized NQTLs (i.e., prior authorization, concurrent review, step therapy/fail first, standards for provider network admission, and/or standards for providing access to out-of-network providers) 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 following worksheets: "M_Intro-NQTL-MCO" and "N_NQTL-MCO",_ - "S_Intro-NQTL-CHIP" and "T_NQTL-CHIP," and "Y_Intro-NQTL-ABP" and "Z_NQTL-ABP." If the State applies additional, non-prioritized NQTLs, the State should enter information regarding these NQTLs in the "M_Intro NQTL-MCO", "S_Intro NQTL-CHIP", and/or the "Y_Intro NQTL-ABP" worksheets, as necessary based on the program type.

Aggregate Lifetime and Annual Dollar Limits (Medicaid MCO)

Regulatory basis for the section

Medicaid MCO: 42 CFR § 438.905.

CHIP: This section is not applicable CHIP 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.[28]

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

Overall Layout

The State should complete the set of questions, as necessary, in the "J_AL-ADL-MCO" worksheet by benefit package within the given program type. For example, if there are two benefit packages, 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 being 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 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 then indicate the entity(ies) providing MH and/or SUD benefits in the Entity Providing MH/SUD Benefits Column (Column C). The State should enter the entity(ies) 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, it is acceptable to list all entities in

[28] See footnote 25 on p.18 for information re: regulatory changes to be codified at 42 CFR § 457.480.
[29] However, under 42 C.F.R. § 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.

one cell and repeat the information for IDs# 1-8 if they apply the same limitations. Below are multiple examples to demonstrate how entries should be made in the worksheet depending on the scenario.

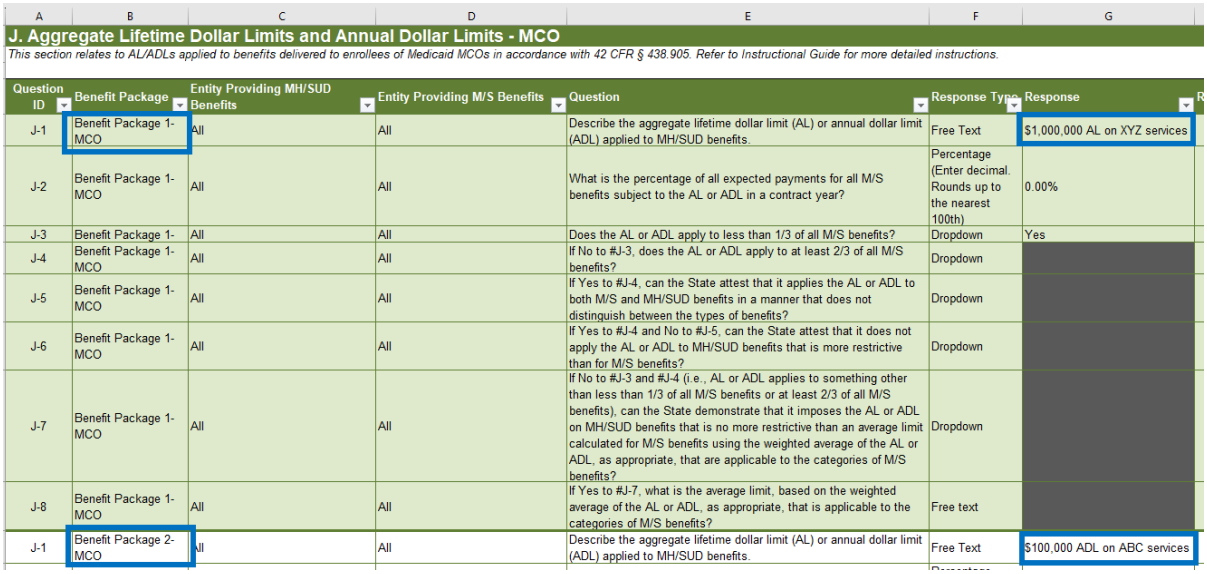
- If MCO A and MCO B both provide MH/SUD and M/S benefits, and use the same AL within the benefit package, both MCOs can be entered in Columns C and D.
- If MCO A uses a different type of AL than MCO B, the question set (IDs# 1-8) should be answered once for MCO A and again, separately beginning on ID# 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-N 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-N.

For example, if, for a benefit package, a State includes both an AL and ADL, the State should enter the AL in ID# 1 Response Column (Column G), and the ADL in ID# 1 Response2 Column (Column H). For example, if there is an AL indicated in ID# 1, Response Column (Column G), and an ADL in ID# 1, Response2 Column (Column H), 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, the State 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 for more detailed instructions.						
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-	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	All	All	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

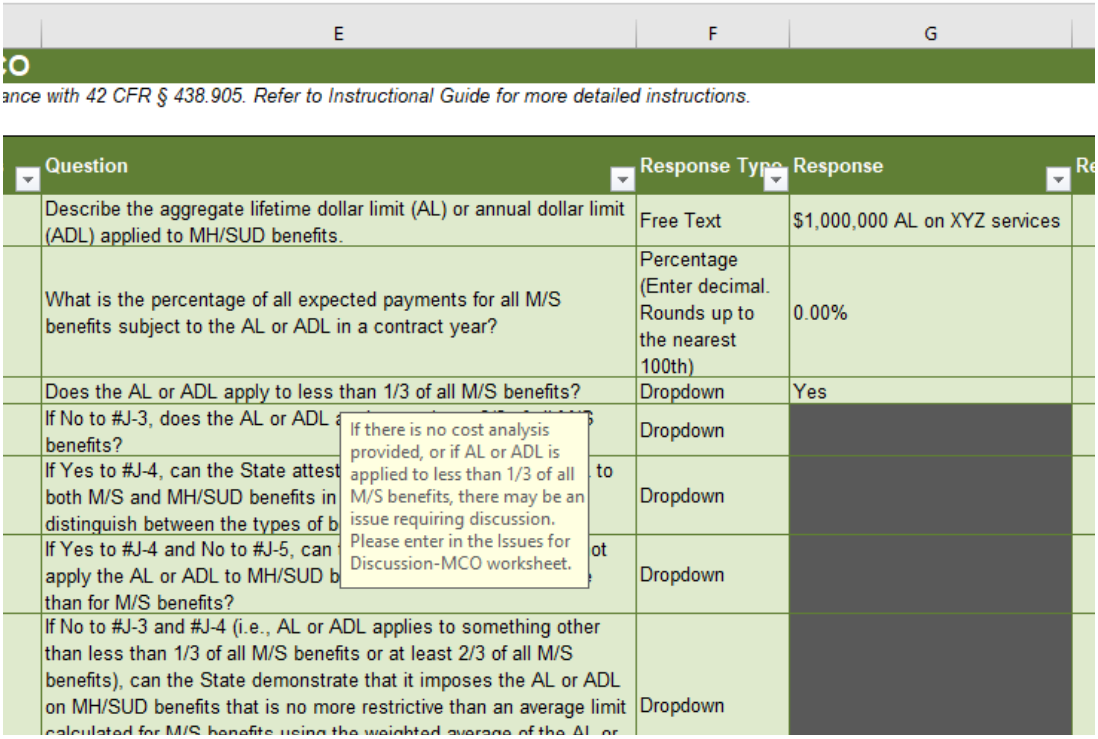
Instructions

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.

Please note that conditional formatting is built into the worksheet to guide the State as to which questions should still 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 automatically 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



Financial Requirements (Medicaid MCO, CHIP, ABP)

Regulatory basis for the section

Medicaid MCO: 42 CFR § 438.910(a)-(c)

CHIP: 42 CFR § 457.496(d)(1)-(3)

ABP: 42 CFR § 440.395(b)(1)-(3)

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 being described in the Benefit Package Column (Column B) using the drop-down options for benefit packages available in ID# 1.[31] Note that the benefit package can only be selected using ID# 1; once selected, it will

[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.

automatically generate the same benefit package for IDs# 2-7 in Column B for one set of questions.

The State should then indicate the entity(ies) providing MH and/or SUD benefits in the Entity Providing MH/SUD Benefits Column (Column C). The State should indicate 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, it is acceptable to list all entities in one cell and have the information repeat for IDs# 1-7. Below are multiple examples to demonstrate how entries should be made in 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.

Figure 11: Example FR worksheet with entities applying distinct FRs in the same benefit package

K. Financial Requirements - MCO

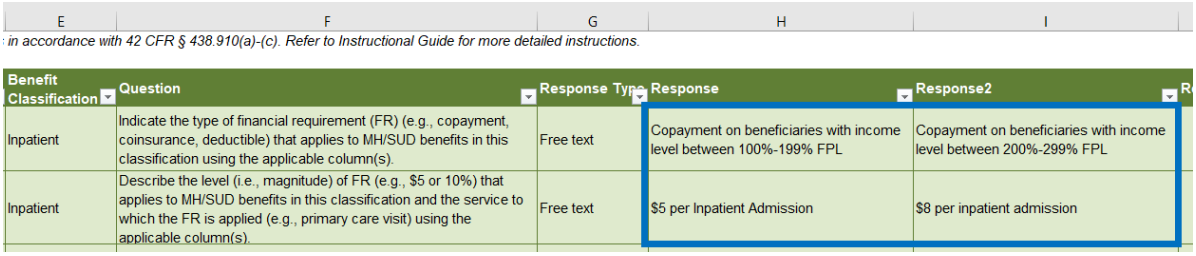
This section relates to FRs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(a)-(c). Refer to Instructional Guide for more detailed instructions.

Question ID	Benefit Package	Entity Providing MH/SUD Benefits	Entity Providing M/S Benefits	Benefit Classification	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 this type of FR.	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 (e.g., primary care visit) using the	Free text	$8 per inpatient admission

Each question set (IDs# 1-7) relates to one benefit classification only. The State should select from the drop-down options (i.e., inpatient, outpatient, emergency care, prescription drugs) to indicate in which benefit classification the FRs are applied in the Benefit Classification Column (Column E). 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-M 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-M (the State should use as many columns as necessary to capture all FRs within each benefit package). 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
in accordance with 42 CFR § 438.910(a)-(c). Refer to Instructional Guide for more detailed instructions.				
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

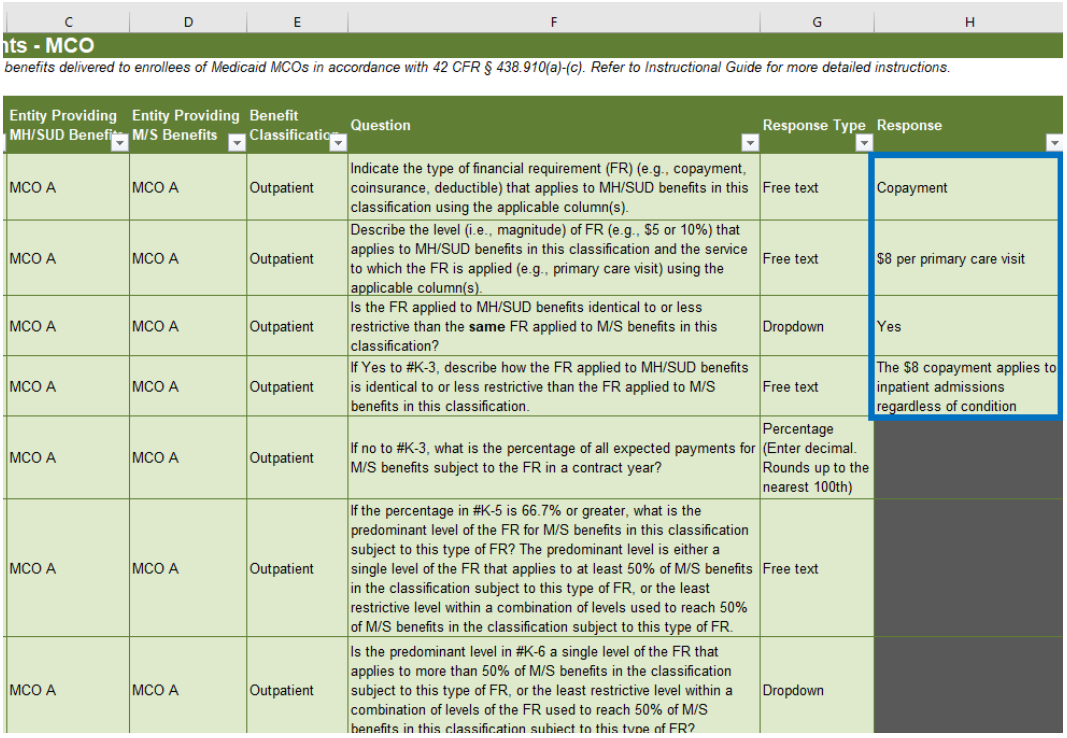
Instructions

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, as required by 42 CFR §§ 438.910(a)(3), 440.395(b)(1)(iii), and 457.496(d)(1)(iii). 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 (or services) 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 the State provides a description of how this is the case in ID# 4 – the State does not need to answer the remaining questions in the set (IDs# 5-7).[32] For example, if the copayment for an inpatient admission is $8 for both MH/SUD and M/S benefits 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 benefits are 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 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)

Figure 13: Example FR worksheet showing conditional formatting based on responses



C	D	E	F	G	H
nts - MCO					
benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(a)-(c). Refer to Instructional Guide for more detailed instructions.					
Entity Providing MH/SUD Benefits	Entity Providing M/S Benefits	Benefit Classification	Question	Response Type	Response
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
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	$8 per primary care visit
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
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 $8 copayment applies to inpatient admissions regardless of condition
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)	
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 this type of FR.	Free text	
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 is not able to provide a description of how this is the case, the State 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[33].

[32] 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.

[33] See Section 5.2 The Two-Part Test for Financial Requirements (FRs) and Quantitative Treatment Limitations (QTLs), in Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, p. 21-25.

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 per 42 CFR §§ 438.910(b)(1), 440.395(b)(2)(i), and 457.496(d)(2), and IDs# 6-7 will turn gray. **If the FR is still applied to MH/SUD benefits when the percentage of all M/S benefits subject to the FR is less than 66.7%, this should be noted in the Issues for Discussion worksheet**.

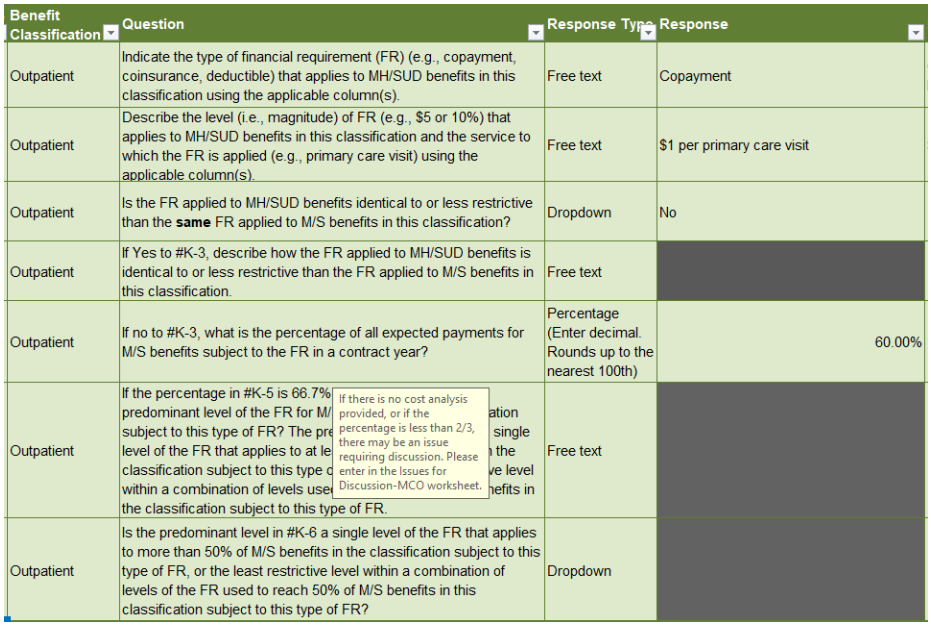
If the percentage in ID# 5 is 66.7% or greater, the State should enter the predominant level of the FR in ID# 6. The predominant level is the level of the FR (e.g., $5) that applies to more than half (50%) of all M/S benefits in the classification. For the predominant level provided in response to ID# 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")[34] 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 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, the State should describe it in the applicable Issues for Discussion worksheet.

Note that conditional formatting is built into the worksheet to guide the State as to which questions should be answered based on 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, the State should still respond to ID# 4, but IDs# 5-7 will automatically turn gray to indicate that no response is necessary.

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").

[34] 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



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	$1 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 66.7% predominant level of the FR for M/ subject to this type of FR? The pre level of the FR that applies to at le classification subject to this type c within a combination of levels use 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.

Quantitative Treatment Limitations (Medicaid MCO, CHIP, ABP)

Regulatory basis for the section

Medicaid MCO: 42 CFR § 438.910(a)-(c)

CHIP: 42 CFR § 457.496(d)(1)-(3)

ABP: 42 CFR § 440.395(b)(1)-(3)

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 the "L_QTL-MCO," "R_QTL-CHIP," and "X_QTL-ABP" 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 being described in the Benefit Package Column (Column B) using the drop-down options for benefit packages available in ID# 1.[35] 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.

[35] 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.

The State should then indicate the entity(ies) providing MH and/or SUD benefits in the Entity Providing MH/SUD Benefits Column (Column C). The State should indicate 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, it is acceptable to list all entities in one cell and have the information repeat for IDs# 1-7. Below are multiple examples to demonstrate how entries should be made in 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 services 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.
- 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. The State 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 E). 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-M are for responses that relate to ***different types of QTLs*** (e.g., episode, day, or visit limits), as applicable. 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-M (the State should use as many columns as necessary to capture all QTLs within each benefit package). 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.

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 or services that ***cannot*** be exceeded by medical necessity criteria; in other words, there is no process by which the entity providing benefits (e.g., managed care plan) can exceed the numerical limitation. If the entity providing benefits can exceed the numerical limitation based on a medical necessity determination or some other process, this would be an NQTL.[36]

In ID# 2, the State should then indicate the level or magnitude of the QTL indicated in ID# 1, as required by 42 CFR §§ 438.910(a)(3), 440.395(b)(1)(iii), and 457.496(d)(1)(iii). 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 (or services) 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 in the classification – and the State provides a description of how this is the case in ID# 4 – the State does not need to complete the remaining questions in the set (IDs# 5-7).[37]

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 if the State is not able to provide a description of how this is the case, the State 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.

[36] See Section 6.1, Identifying and Analyzing Non-Quantitative Treatment Limitations (NQTLs), Section 6.1 in Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, p. 34

[37] 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.

Figure 15: Example QTL worksheet showing conditional formatting based on responses

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 for more detailed instructions.

Question ID	Benefit Package	Entity Providing MH/SUD Benefi	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	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.

If the percentage entered 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 per 42 CFR §§ 438.910(b)(1), 440.395(b)(2)(i), and 457.496(d)(2). If the QTL is still applied to MH/SUD benefits when the percentage of all M/S benefits subject to the QTL 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 (50%) 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")[38] 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.

Note that conditional formatting is built into the worksheet to guide the State as to which questions should be answered based on 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, the State should still respond to ID #4, but IDs# 5-7 will automatically turn gray to indicate that no response is necessary.

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").

Figure 16: Example QTL worksheet showing pop-up box flagging an Issue for Discussion

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 for more detailed instructions.

Question ID	Benefit Package	Entity Providing MH/SUD Benefits	Entity Providing M/S Benefits	Benefit Classification	Question	Response Type	Response
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
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
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
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	
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 what is the predominant benefits in this classificat of QTL? The predominar level of the QTL that app M/S benefits in the classi type of QTL, or the least combination of levels used to reach 50% of M/S benefits in the classification subject to this type of QTL.	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 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.

[38] 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.

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

Overall Layout

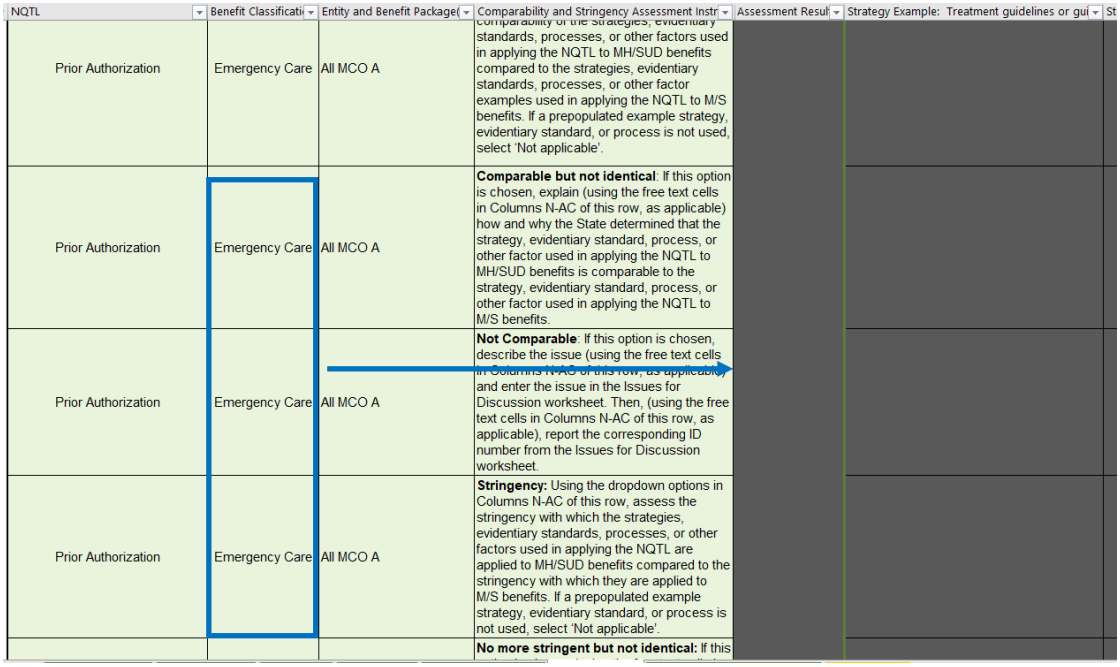
The Intro NQTL worksheets ("Intro NQTL-MCO," "Intro NQTL-CHIP," and "Intro NQTL-ABP") require the State to provide an overview of how the five prioritized NQTLs are applied within all benefit packages, by all entities providing MH and/or SUD benefits, and in all benefit classifications, as applicable based on the State's program types. The instructions and layout for the "M_Intro NQTL-MCO," "S_Intro NQTL-CHIP," and "Y_Intro NQTL-ABP" worksheets are the same. Before the State completes the NQTL comparative analyses in the NQTL worksheets ("N_NQTL-MCO," "T_NQTL-CHIP," and "Z_NQTL-ABP"), the State should enter preliminary information in the Intro NQTL worksheets. ***It is critical that the State completes these worksheets accurately and comprehensively. The entries in the Intro-NQTL worksheets directly impact the organization of the subsequent NQTL worksheets.*** Completing the Intro NQTL worksheets properly not only supports the State in providing accurate and comprehensive NQTL comparative analyses, but it can also significantly reduce the amount of data entry in the NQTL worksheets.

For example, the Intro-NQTL worksheets require the State to indicate to which benefit classification(s) each of the five priority NQTLs apply. If a State indicates in the Intro-NQTL worksheets that prior authorization is not applied to emergency care (see Figure 17) within a benefit package, then the corresponding prior authorization fields in the NQTL worksheets (see Figure 18) would turn gray and would not require data entry.

Figure 17: Example Intro-NQTL worksheet with benefit classification selections

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	Blue Cross	All	Yes	Yes	No	Yes
Prior Authorization	Aetna	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 gui	St
Prior Authorization	Emergency Care	All MCO A	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'.			
			No more stringent but not identical: If this			

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 it is possible that this entity(ies) apply(ies) the same NQTL(s) identically in the same benefit classifications, across program types—there is space in Column K to indicate if the State 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.

Instructions

The State should begin the Intro NQTL worksheets by completing "Step-1: Priority NQTLs". The State should enter the following data by NQTL into each of the columns in the table:

- NQTL Column (Column D)
  - This field will be prepopulated, as the NQTLs listed are the five prioritized 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 which 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). Please see instructions immediately below that describe when the State should enter more than one benefit package into a single row in the Benefit Package Column (Column F).
    - 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.
        - 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.
        - 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.
    - In a separate 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."

- Benefit Classifications Column (Columns G-J)
  - For each benefit classification (i.e., inpatient, outpatient, emergency care, and prescription drugs), 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.
- 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 it applies the NQTL in an identical manner as they do for this benefit package(s) Column (Column K)
  - As described above, it is possible for States to have MCO, CHIP, and/or ABP benefit packages that use the same entity(ies) to provide MH, SUD, and/or M/S benefits, and that apply the same NQTL(s) identically in the same benefit classifications.
  - 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 MCOY 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 program type, 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.

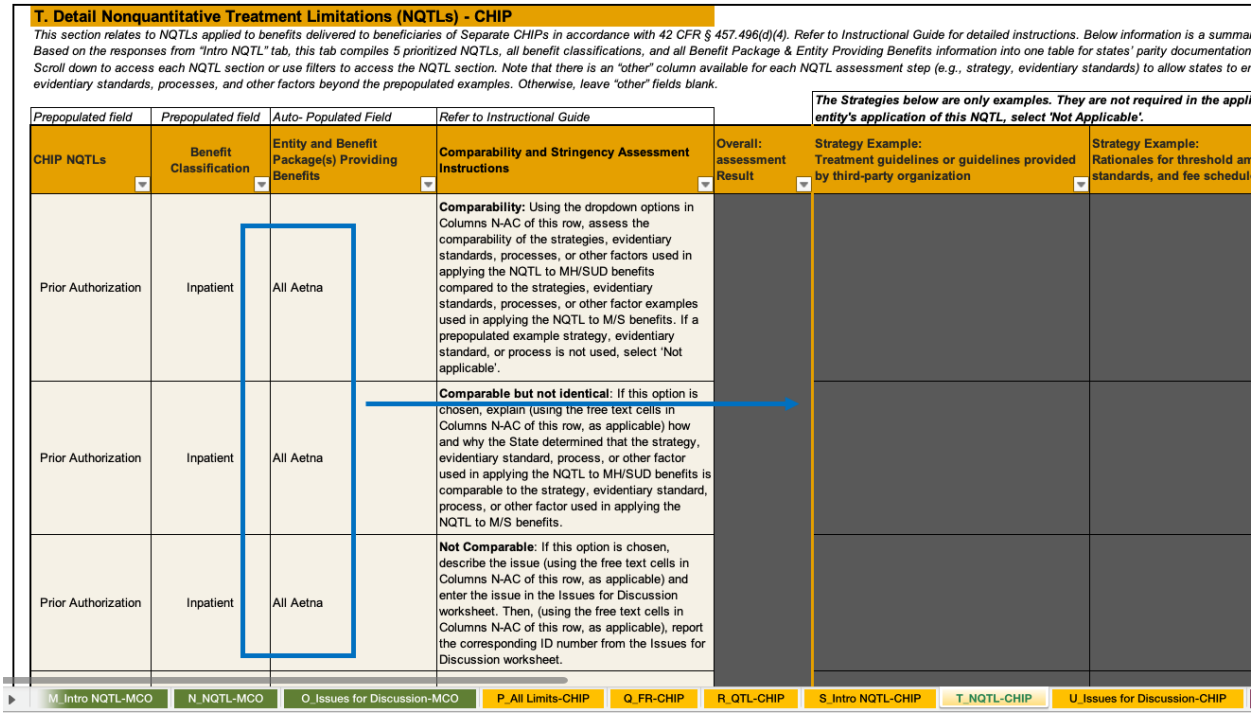
  - In this example, the State should select "Y" in column K of the "Intro-NQTL-ABP" worksheet (see Figure 19), and all data fields corresponding to MCO B in the "NQTL-ABP" worksheet will turn gray and do not need to be completed (see Figure 20).

- 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

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-MCO
All	Yes	Yes	No	Yes	No	NQTL-ABP
All	Yes	Yes	No	Yes	No	NQTL-MCO

Figure 20: Example NQTL-CHIP worksheet showing the impact of selecting that an entity's NQTL assessment can be found on another worksheet



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 for detailed instructions. Below information is a summa
Based on the responses from "Intro NQTL" tab, this tab compiles 5 prioritized NQTLs, all benefit classifications, and all Benefit Package & Entity Providing Benefits information into one table for states' parity documentation
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 standards) to allow states to er
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 the appli entity's application of this NQTL, select 'Not Applicable'.

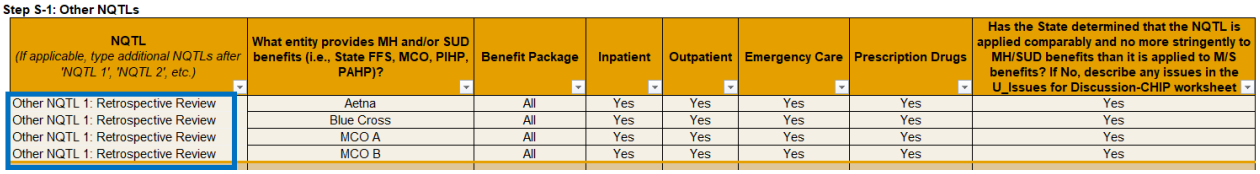
Prepopulated field	*Prepopulated field*	*Auto- Populated Field*	*Refer to Instructional Guide*			
CHIP NQTLs	**Benefit Classification**	**Entity and Benefit Package(s) Providing Benefits**	**Comparability and Stringency Assessment Instructions**	**Overall: assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organization**	**Strategy Example: Rationales for threshold an standards, and fee schedul**
Prior Authorization	Inpatient	All Aetna	**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 Aetna	**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 Aetna	**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.			

M_Intro NQTL-MCO | N_NQTL-MCO | O_Issues for Discussion-MCO | P_All Limits-CHIP | Q_FR-CHIP | R_QTL-CHIP | S_Intro NQTL-CHIP | T_NQTL-CHIP | U_Issues for Discussion-CHIP

Accurately completing the final two columns of "Step 1: Priority 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.

The State should then complete "Step 2: Other NQTLs". The step includes a second table where a State should list other, non-prioritized, NQTLs applied by entities providing benefits in the State. Columns D-J ask the State to provide the same information regarding the NQTL, entity providing MH and/or SUD benefits, benefit package, and applicable benefit classifications as required by "Step 1: Priority NQTLs". The only difference is that the NQTL Column (Column D) is not pre-populated in this table. Rather the State must enter any additional NQTLs applied by the entities providing benefits in the State.

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



Step S-1: Other NQTLs

NQTL *(If applicable, type additional NQTLs after 'NQTL 1', '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 applied comparably and no more stringently to MH/SUD benefits than it is applied to M/S benefits? If No, describe any issues in the U_Issues for Discussion-CHIP worksheet**
Other NQTL 1: Retrospective Review	Aetna	All	Yes	Yes	Yes	Yes	Yes
Other NQTL 1: Retrospective Review	Blue Cross	All	Yes	Yes	Yes	Yes	Yes
Other NQTL 1: Retrospective Review	MCO A	All	Yes	Yes	Yes	Yes	Yes
Other NQTL 1: Retrospective Review	MCO B	All	Yes	Yes	Yes	Yes	Yes

The second table does not include the same Columns K-L as required in "Step 1: Priority NQTLs". ***This is because no detailed analysis for these additional, non-prioritized NQTLs is required to be entered in the "N_NQTL-MCO," "T_NQTL-CHIP," and "Z_NQTL-ABP" worksheets in this template.*** Therefore, there is no need to avoid data entry duplication.

Rather, 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 confirmation (or not) 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.

Nonquantitative Treatment Limitations (Medicaid MCO, CHIP, ABP)

Regulatory basis for the section

Medicaid MCO: 42 CFR § 438.910(d)

CHIP: 42 CFR § 457.496(d)(4)

ABP: 42 CFR § 440.395(b)(4)

Overall Layout

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

As described in 42 CFR § 438.910(d)(1), 42 CFR § 457.496(d)(4)(i), and 42 CFR § 440.395(b)(4)(i) for Medicaid MCOs, CHIPs, and ABPs, respectively, **comparability assessments** should determine whether any strategies, evidentiary standards, processes, or other factors "used in applying" the NQTL to MH/SUD are comparable to those processes, strategies, evidentiary standards, or other factors "used in applying" the NQTL to M/S. **Stringency assessments** should determine whether these same processes, strategies, evidentiary standards, or other factors "are applied no more stringently than" to MH/SUD than to M/S. These assessments must assess the imposition of the NQTL "as written and in operation."[39] However, stringency assessments may focus on the "in operation" application of the processes, strategies, evidentiary standards, or other factors.

Section 6 of the CMS Parity Compliance Toolkit[40] provides background information on NQTLs, and some examples related to comparability and stringency, including:

- *Part 1.* 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

[39] 42 CFR § 438.910(d)(1), 42 CFR § 457.496(d)(4)(i), and 42 CFR § 440.395(b)(4)(i) for Medicaid MCOs, CHIPs, and ABPs, respectively

[40] See Section 6.3 Examples Illustrating Each Part of the NQTL Analysis, in Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, p. 35.

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*.

- *Part 2*. 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

States should document their comparability and stringency assessments of five prepopulated priority NQTLs within the Template:

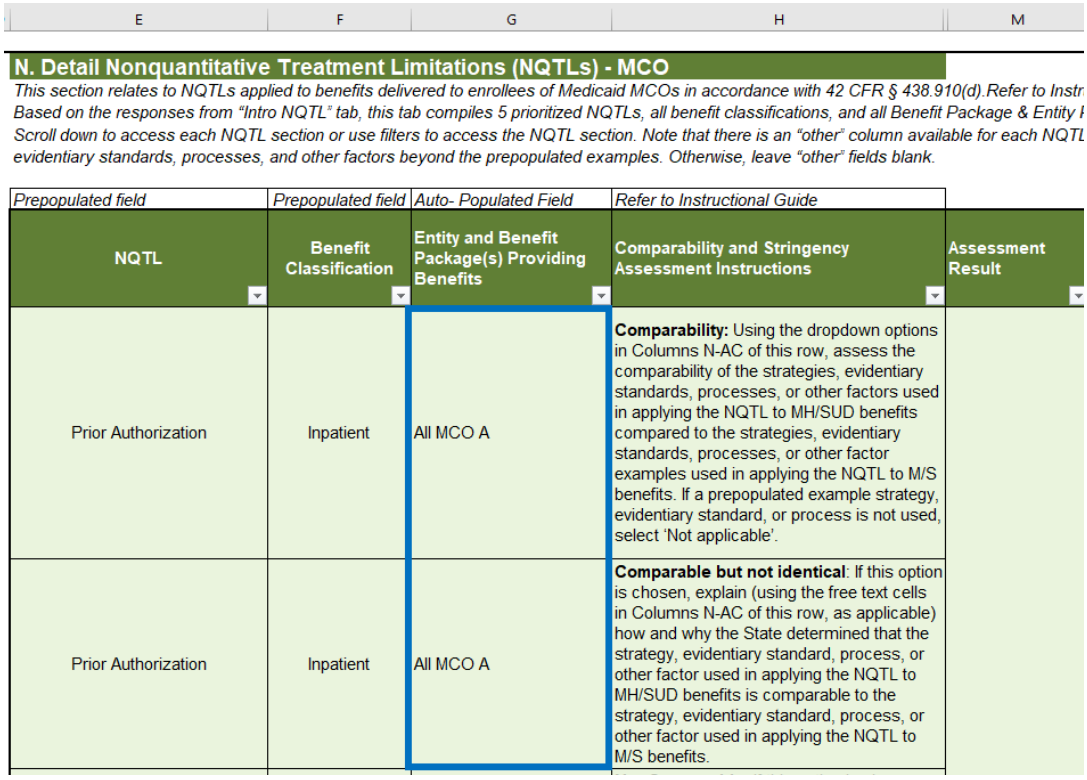
1. Prior Authorization
2. Concurrent Review
3. Step Therapy/Fail First
4. Standards for Provider Network Admission *(only required for analyses that include one or more entity(ies) establishing a provider network, separate from the FFS network)*
5. Standards for Access to Out-of-Network Care *(only required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

States should perform and document their assessments for each of these NQTLs, if applicable; 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).

Figure 2222: Example NQTL worksheet showing auto-populated entities/benefit packages



E | F | G | H | M

N. Detail Nonquantitative Treatment Limitations (NQTLs) - MCO

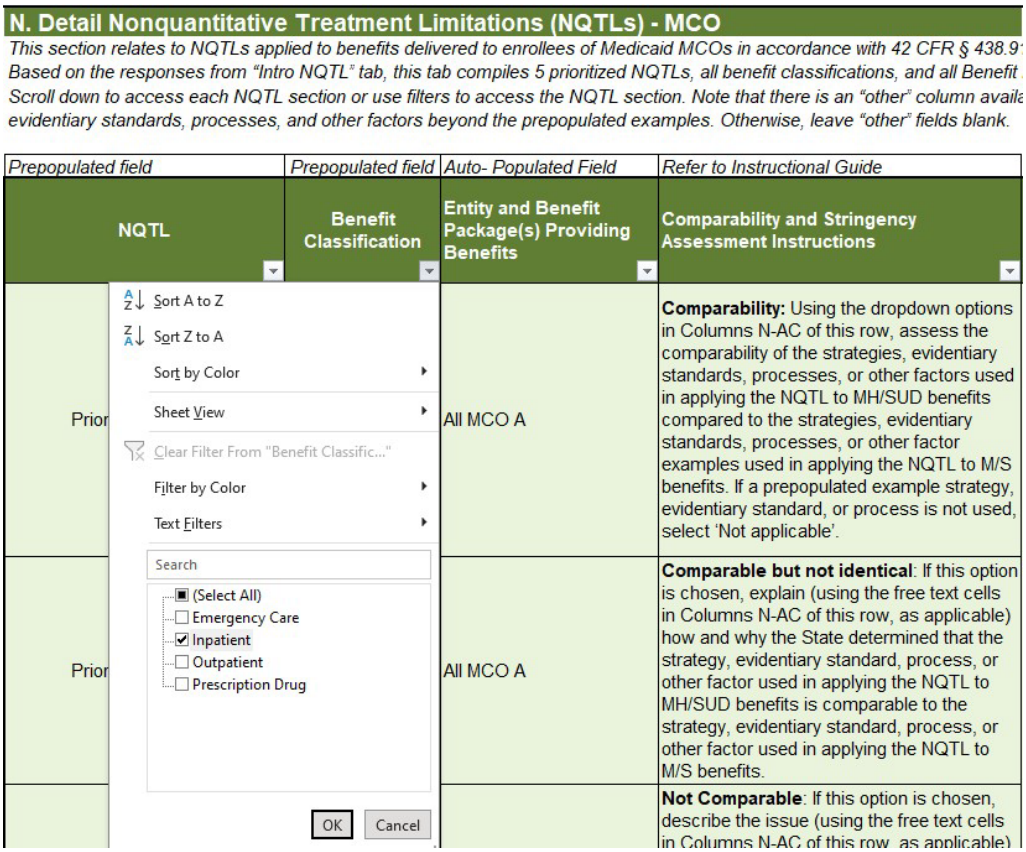
This section relates to NQTLs applied to benefits delivered to enrollees of Medicaid MCOs in accordance with 42 CFR § 438.910(d).Refer to Instr
Based on the responses from "Intro NQTL" tab, this tab compiles 5 prioritized NQTLs, all benefit classifications, and all Benefit Package & Entity I
Scroll down to access each NQTL section or use filters to access the NQTL section. Note that there is an "other" column available for each NQTL
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**	**Assessment Result**
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.	

Excel User Tip:

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. See an example in Figure 23.

Figure 23: Example of how to "filter" NQTL worksheet



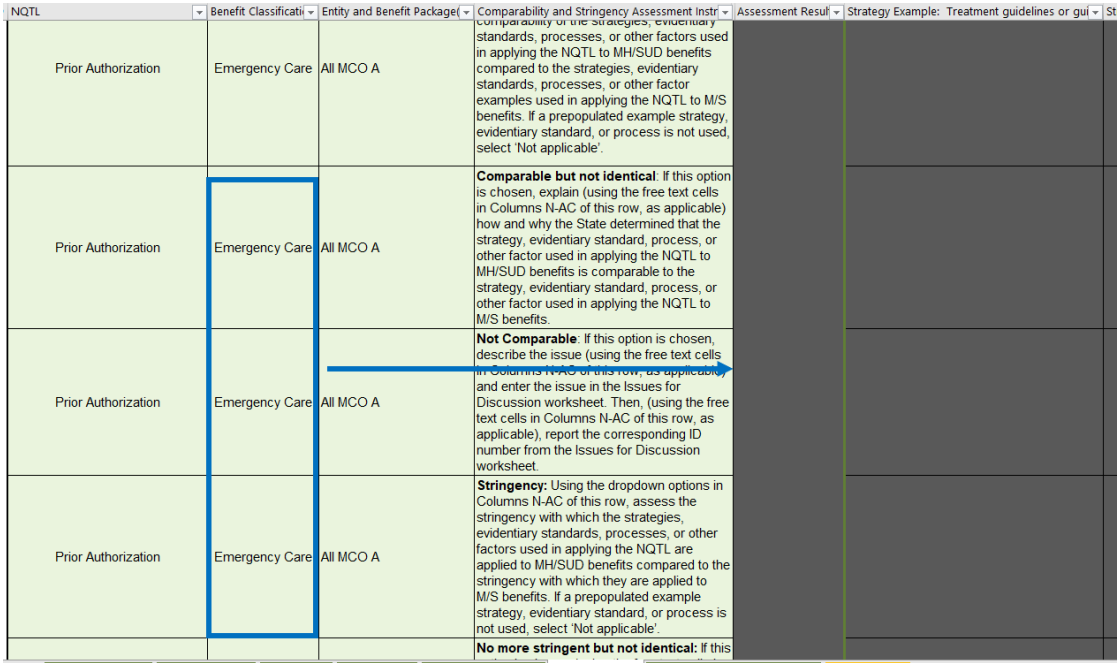
The Comparability and Stringency Assessments Column (Column H) contains prepopulated language that provides instruction related to the corresponding data fields in the same rows across Columns N-AC.

As noted, fields for each benefit classification are prepopulated within the Template. 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 2424: Example Intro-NQTL worksheet with benefit classification selections

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	Blue Cross	All	Yes	Yes	No	Yes
Prior Authorization	Aetna	All	Yes	Yes	No	Yes

Figure 2525: Example NQTL worksheet demonstrating the impact of the benefit classification selections in the corresponding Intro-NQTL worksheet



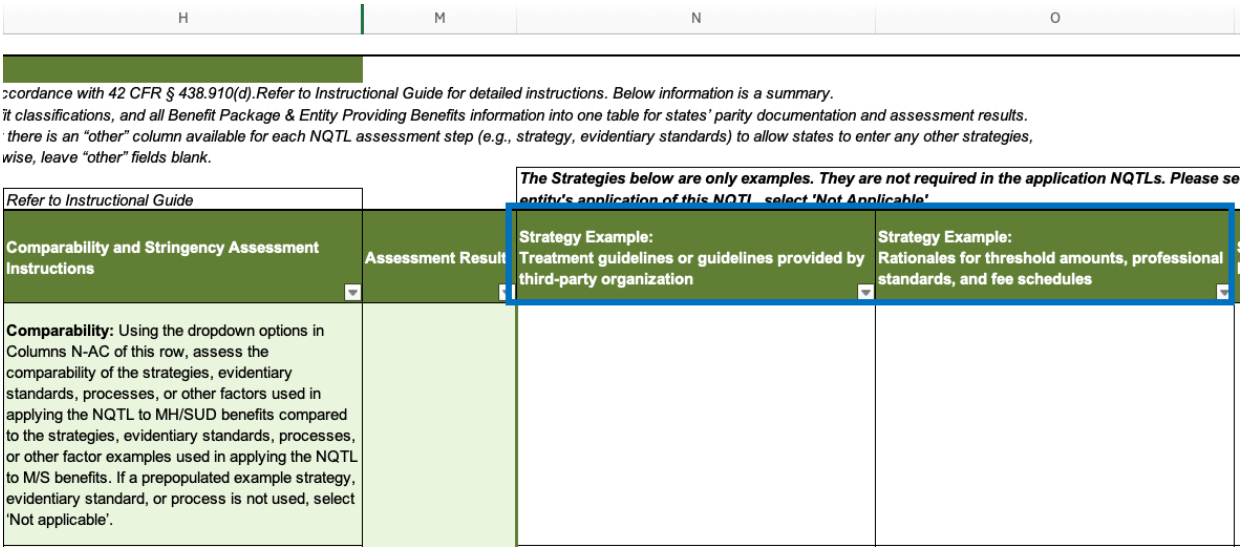
NQTL	Benefit Classificati	Entity and Benefit Package(	Comparability and Stringency Assessment Instr	Assessment Resul	Strategy Example: Treatment guidelines or gui	St
Prior Authorization	Emergency Care	All MCO A	standards, processes, or other factors used in applying the NQTL to MH/SUD benefits compared 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'.			
			No more stringent but not identical: If this			

Instructions

States should assess the comparability and stringency for each of the strategies, evidentiary standards, processes, and other factors that the entity employs when designing and applying each of the five priority NQTLs, per 42 CFR §§ 438.910(d)(1), 440.395(b)(4)(i), and 457.496(d)(4)(i). The State should complete this analysis of comparability and stringency by reviewing and comparing information from the entity(ies) that provide(s) MH and/or SUD benefits with information from the entity(ies) that provide(s) M/S benefits. The results of this analysis should be documented and summarized in this Template.

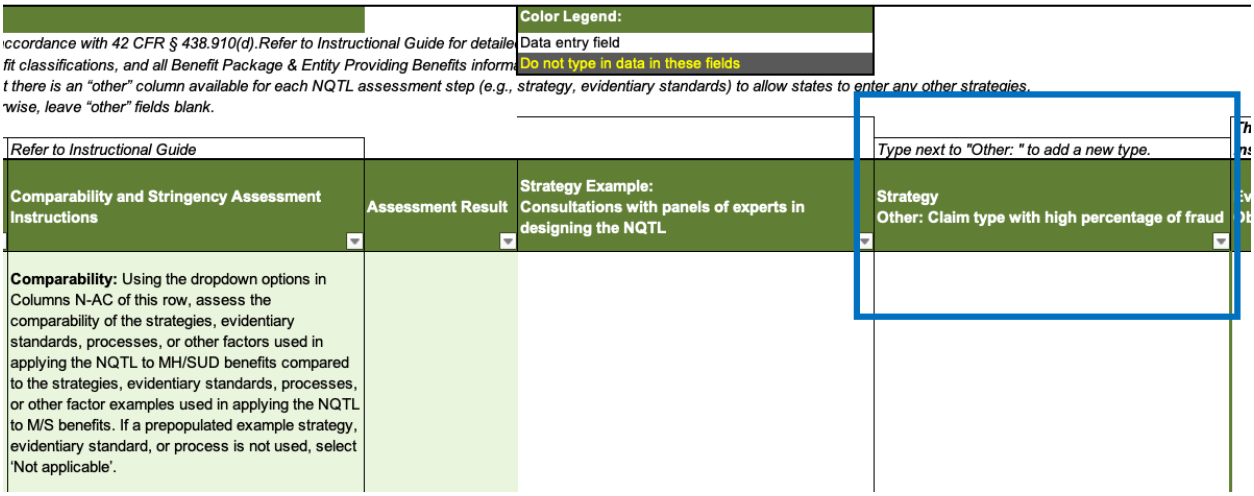
To improve consistency and reduce administrative burden, the Template includes prepopulated examples strategies, evidentiary standards, and processes, plus additional fields for the State to enter 'other factors', in columns N-AC of the Header row (see Figure 26). ***The prepopulated strategies, evidentiary 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 2626: Example examples of strategies, evidentiary standards, and processes in the NQTL Worksheet



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. 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).

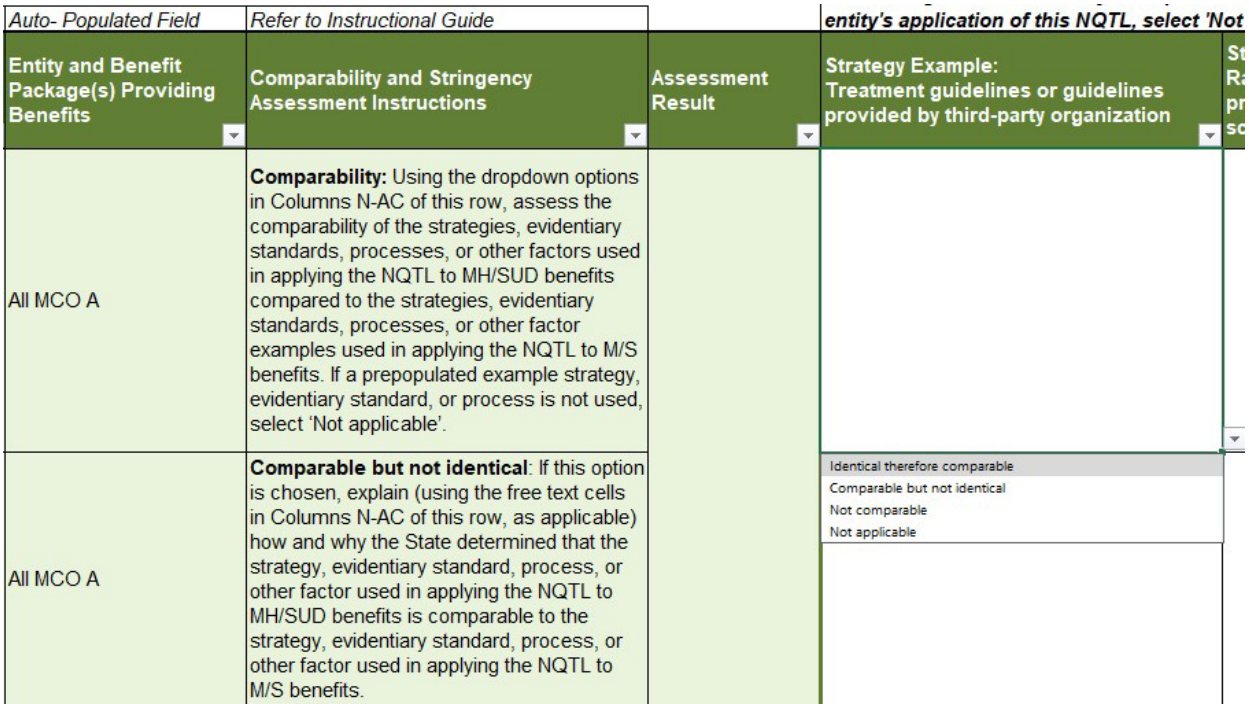
Figure 2727: Example of "Other" columns for additional strategies, evidentiary standards, and processes



Please note: the instructions below discuss a comparability assessment, but the steps and instructions are the same when documenting stringency assessments within the Template.

For each prepopulated example or State-entered a strategy, evidentiary standard, process, and/or other factor, the State should first select from the 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 of the entity's compliance with comparability assessments.

Figure 2828: Example NQTL worksheet showing comparability assessment drop-down options



Auto- Populated Field	*Refer to Instructional Guide*		***entity's application of this NQTL, select 'Not***
Entity and Benefit Package(s) Providing Benefits	**Comparability and Stringency Assessment Instructions**	**Assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organization**
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 is necessary to determine 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 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 InterQual criteria are used 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 InterQual criteria are used for M/S benefits, but a separate, but still objective third-party standard is used 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 Template contains conditional formatting so that if this option 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," the State 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).

Figure 2929: Example NQTL worksheet with an assessment of "Not Comparable"

Refer to Instructional Guide		***entity's application of this NQTL, select 'Not A***
Comparability and Stringency Assessment Instructions	**Assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organization**
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 number from the Issues for Discussion worksheet.		Health Plan A uses plan-developed treatment guidelines for MH/SUD, but uses Interqual for M/S benefits. **ID Number O-1**

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.

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 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, and no data entry is needed.

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 30), 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".

Figure 3030: Example NQTL worksheet showing the "Assessment Result" field

Benefit Classification	Entity and Benefit Package(s) Providing Benefits	Comparability and Stringency Assessment Instructions	Assessment Result	Strategy Example: Treatment guidelines or guidelines provided by third-party organization
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		
		Comparability: Using the dropdown options	Met Not Met	

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

Issues for Discussion (Medicaid MCO, CHIP, ABP)

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.

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

Figure 31: Example of a "New" issue for discussion entry

O. Issues for Discussion - MCO

Refer to Instructional Guide for detailed instructions.

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	10/01/9999: State will follow-up with MCO A to ensure that comparable treatment guidelines for both MH/SUD and M/S.	12/31/19999	

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 32.

Figure 32: Example of where to add "Issue for Discussion" ID Number

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 Guide for detailed instructions. Below
Based on the responses from "Intro NQTL" tab, this tab compiles 5 prioritized NQTLs, all benefit classifications, and all Benefit Package & Entity Providing Benefits information into one table f
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
evidentiary standards, processes, and other factors beyond the prepopulated examples. Otherwise, leave "other" fields blank.

The Strategies below are only examples. T
entity's application of this NQTL, select 'No

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**	**Assessment Result**	**Strategy Example: Treatment guidelines or guidelines provided by third-party organization**
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'.		Not comparable
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),		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 explain 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 33 provides an example of an updated issue for discussion.

Figure 3333: Example Issues for Discussion worksheet showing an "Update" that resolves an issue

O. Issues for Discussion - MCO

Refer to Instructional Guide for detailed instructions.

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	12/10/9999: State discussed needed change with MCO A on 10/15/9999, and necessary change was implemented on 12/1/9999. 10/01/9999: State will follow-up with MCO A to ensure that comparable treatment guidelines for both MH/SUD and M/S.	12/31/19999	12/1/9999

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 "Identical and no more stringent," 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.

Scenario 3: No Changes

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 34 provides an example of an issue for discussion entry with no changes.

Figure 3434: Example Issues for Discussion worksheet with "No changes"

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	10/01/9999: State will follow-up with MCO A to ensure that comparable treatment guidelines for both MH/SUD and M/S.	12/31/19999	

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 in DPO within MCOG