HHS-CMS-CMCS
October 8, 2024
3:00pm ET

Coordinator: Welcome and thank you for standing by. At this time, I'd like to inform all participants that today's call is being recorded. If you have any objections, you may disconnect at this time. All lines have been placed in a listen-only mode for the duration of today's conference.

I would now like to turn the call over to Miss Jackie Glaze. Thank you, ma'am. You may begin.

Jackie Glaze: Thank you, and good afternoon. And welcome everyone to today's All State Call In Webinar. I'll now turn it - turn to Dan Tsai, our Center Director for opening remarks. Dan?

Dan Tsai: Hi. Thanks, Jackie. Hi everybody. Good afternoon. I just wanted to start, before we get into the agenda for today, I just want to note we've got quite a number of states who are facing, one, and now two, intense hurricanes, and so I think our thoughts are with our state colleagues, the people in those states.

I know our staff are working with quite a number of states on PHE 1135 flexibilities, waivers, anything needed. So I just emphasize anybody that

needs any support from CMS, CMCS on any flexibility or support please just let us know our team is prioritizing that, so thank you all for that.

And then for today's call we are primarily going to focus on a proposed set of tools that we recently put out for comment on mental health parity, MHPAEA compliance, on the Medicaid side. As folks know, there was a broader rule that went out for the broader market.

And alongside Inside that we put out some additional proposed templates and instructional guides for state agencies to standardize and make more consistent and hopefully a little bit easier for how states need to document their mental health and SUD benefits, particularly through states MCO program, Alternative Benefit Plans, and CHIP in order to comply with the requirements of MHPAEA.

And so Kirsten Beronio, who is a senior advisor for behavioral health here on the Medicaid Team, will walk through those templates and guides really to get informal feedback and comments from all of our state partners and others. And she'll go through kind of the deadlines for comment as well.

And so before we get started housekeeping folks should log into the Webinar platform. You'll see slides on that, if you're not logged in already, you can do so now. And you can also submit any questions you have into the chat at any time during the presentation. And with that I am going to turn it over to Kirsten Beronio. So Kirsten, over to you, thanks.

Kirsten Beronio: Thanks, Dan, and hello everyone. Thanks for joining us. I think we can go to the next slide. We already kind of covered why we're here, so next slide, please. And the next slide. I'm going to provide a little bit of background and context and actually then turn it over to some folks we've been working with

at miter to give a walk-through demonstration of the templates so that we can help, again, primarily help you all, states and stakeholders, respond to our request for comment that was posted on September 9.

So we've developed these new templates and instructional guides to help states document how their Medicaid and separate CHIP mental health and substance use disorder benefits comply with the Medicaid and CHIP parity regulations. There's a link there to those 2016 final rules, again, the Medicaid and CHIP regulations. And we posted these draft templates and guides on September 9 at that link in the second bullet, really looking for your feedback on these tools.

As you may know most provisions of the Mental Health Parity and Addiction Equity Act of 2008, MHPAEA, applied to coverage provided to enrollees of Medicaid-managed care organizations, coverage provided by Medicaid Alternative Benefit Plans, and separate CHIP programs regardless of delivery system.

And these parity requirements actually do not apply to Medicaid beneficiaries who are not enrolled in an MCO or in an Alternative Benefit Plan or - and who receive only state plan services via fee-for-service or prepaid inpatient health plans or prepaid ambulatory health plans.

So when a beneficiary is primarily enrolled in fee-for-service or a PIP or a PAP and there's no MCO or ABP enrollment, then parity doesn't technically apply, but we do encourage states to ensure compliance with parity regardless of delivery system because we do know that it's so important for improving access to care for beneficiaries who have mental health or SUD needs.

Next slide, please. So this slide just provides an overview of our current

processes for ensuring compliance with parity in Medicaid and CHIP. So with regard to Medicaid MCO programs, states submit the parity documentation to CMS with the MCO contract for review and approval. And states are also required to post that parity documentation on their Web site.

For separate CHIP programs states submit state plan amendments and provide the documentation to us on how they are complying with parity and those benefits. And then also for Alternative Benefit Plans, states submit state plan amendments to us to identify any benefit limitations and provide descriptions of how the benefits demonstrate compliance with parity requirements.

So next slide please. Again, the draft templates that we posted for comment are intended to clarify for states and plans what information to submit to demonstrate compliance with parity in a more standardized format. These templates are also intended to streamline the review process and minimize submission of duplicative information and coordinate review internally at CMS among our divisions, and also reduce time spent by states and plans collecting information to document compliance in order to improve efficiency but also effectiveness of review and analysis of the information submitted.

So next slide please. So just a very high-level overview of these tools, there are two types. One set is the managed care plan and state fee-for-service templates. And those are designed to help states collect information from their managed care plans and information regarding their fee-for-service benefits in order to help them complete the state summary template, which then the state would submit to CMS in order to demonstrate compliance with parity. And that's what the CMS staff would review to ensure compliance.

So next slide please. We will try to get to some Q&As, but in any case, we do

encourage you to submit your comments to this mailbox that we have set up to collect comments. And, you know, any comments submitted today can't really be considered part of that official submission.

We did originally set the deadline for comments at October 29, but we, in light of some requests from stakeholders and then to ensure adequate time to really receive robust comments, we are extending that deadline that was announced yesterday to December 2.

And now I'm going to turn it over to Tom Schenk with the MITRE Team that's been helping us to develop these templates and instructional guides to walk us through them. Tom?

Tom Schenck: Thank you, Kirsten. And just one moment while we get screen share. So the RFC is asking for comments on three templates and their respective instructional guides, which you can see links to on the screen here.
The parity state summary template, and this instructional guide, are the first two links.

And then the Plan and Safety for Service Program reporting templates, and a single instructional guide that applies to both. These two templates only have one instructional guide because they are predominantly the same except the terminology is targeted to either a managed care plan or a say fee-for-service Program.

The way this is intended to work is that plans, or state fee-for-service program reporting templates, would be completed and submitted to the state by each managed care plan or fee-for-service program delivering mental health SUD or med-surg benefits that are subject to parity in the state. States would then summarize and document their analysis of all planned fee-for-service program

template information within the state summary template that the state would then submit to CMS.

Today we're going to provide demonstrations of both the plan template and the state summary template. We will not have time to go over all the worksheets and data fields, so please refer to the respective instructional guides as you review and provide comments on these templates. As we go along, please send any questions, especially those related to the functionality or technical aspects of the template, into the chat, and we will respond at the end of the call.

We'll begin by going over the plan template, which as I noted, is predominantly the same as the state fee-for-service program template. To do that I'm going to turn it over to my colleague, (Brooke).

(Brooke): Thank you, Tom. So as Tom mentioned, for this demonstration, we'll be using the managed care plan Reporting Template and refer to managed care plans, or plans, as the entities that provide mental health, or SUD, and/or medical surgical benefits in the state. So, as Tom noted, the term managed care plans is intended to be interchangeable with the term state fee-for-service program for the demonstration of these templates.

We'll first start with an overview of all worksheets in this template, and we'll go back to review in detail certain worksheets. As you'll see here, Worksheet A, is Instructions. It includes instructions and a table of contents. Worksheet B, managed care plan Data, is introductory data such as the state in which the plan operates and contact information for that plan's point of contact, as well as fields related to the analysis. In other words, what is being submitted in this template.

And fields for the applicable benefit packages in the state in which the plan provides benefits, as well as for which types of conditions the plan provides benefits. So you'll see here there's a drop-down for mental health, substance use disorder services, and medical surgical services, or some combination thereof.

The next worksheet is titled All Limits. And this includes a series of yes or no questions intended to be a guide for how to complete the remaining worksheets, which all relate to each of the tests and analyzes required by the Medicaid and CHIP parity regulation. So the first is Aggregate Lifetime and Annual Dollar Limits, or ALADL, Financial Requirements, or FRs, Quantitative Treatment Limits, or QTLs, and Non-Quantitative Treatment Limits, or NQTLs.

So we'll show some functionality here of the template. If the user selects no, i.e., the managed care plan does not apply aggregate lifetime or annual dollar limits and to mental health sub-benefits in any benefit packages, so Worksheet D, as I'll switch to here, grays out. And the user is not able to enter in information here.

You'll also see a message at the top of the sheet indicating that the user can skip this worksheet because of their responses in the All Limits Worksheet. So I'll switch back to the All Limits worksheet for a moment to demonstrate that if the plan, for example, did apply annual dollar limits, so if you hit yes to this question, Worksheet D for Aggregate Lifetime and Annual Dollar Limits would open up and be ready for responses.

I'll return to the All Limits Worksheet for just one more note that this functionality regarding the graying out of cells does not apply to the last question about Non-Quantitative Treatment Limitations. For those

worksheets they need to be filled out manually and individually. And I will go through those shortly.

You'll now see that Worksheets D through F applies to relate to aggregate lifetime and annual dollar limit, financial requirements, and quantitative treatment limits. I'll go back later in the presentation to demonstrate the financial requirement's worksheet in detail.

The next set of worksheets applied to Non-Quantitative Treatment Limitations. You will see that there are separate worksheets per highlighted NQTL per benefit classification, so inpatient, outpatient, emergency care, and prescription drugs. These highlighted NQTLs are prior authorization, concurrent review, step therapy, or fail first, standards for provider network admission, and standards for providing access to out-of-network providers.

These NQTLs are pre-populated in the individual worksheet. And the user should attest to either applying or not applying the NQTL within the benefit classification in each worksheet. And you'll see that here with that yes or no drop-down. We know that state fee-for-service programs may not apply to provider network-related NQTLs, and thus those worksheets will not be applicable.

There are also four additional worksheets included in this template regarding any other types of NQTLs should the user need additional space beyond the highlighted NQTLs. We'll go back in a moment to discuss further details of what should be included on the NQTL worksheets.

Lastly, in the overview, you'll see the last worksheet in the template is titled Issues for Discussion. And this relates to any issues for discussion that a managed care plan may need to discuss with the state regarding any parity

information in the template. A very similar worksheet is also included in the state summary template, and Tom will be going into further detail regarding this worksheet and his demonstration.

So I'll go back now to demonstrate the details for the financial requirement's worksheet. You'll see here, on the left-hand side of the screen, that the user needs to enter the benefit package in which the financial requirement is applied. So in this hypothetical example, let's say this is benefit package one, and this does not auto-populate down, so you need to populate this response for this set of questions, so benefit package one all the way down to this set of questions.

The user will then need to indicate the benefit classification. For this hypothetical example we're going to use the outpatient benefit classification. And by selecting outpatient one it populates outpatient in the rest of the cells for this set of questions.

If there are multiple types of financial requirements applied within one benefit package, within one benefit classification, the user will need to enter information related to an individual financial requirement using the columns across the top of the worksheet. So you see here there's six spaces for different types of financial requirements.

So in this example of benefit package one, for the outpatient benefit classification, we're to be using the hypothetical example of a co-payment and a co-insurance. And that is what you - the user would enter into IDE-1. We'll go through the questions for each of these types of FRs in a moment.

But I did want to note that if the managed care plan offers benefits across multiple benefit packages, and the FRs differ across those benefit packages,

then the user will need to enter information related to those FRs in the next set of questions.

So I'll scroll down in here and show you that this sheet goes on to provide multiple spaces for sets of questions. So for example the user could enter that this applies to the second benefit package and then go forth to indicate all the other responses.

So quickly I'll show a quick demonstration of the questions for each of the types of financial requirements. So again, we're working with the example of a co-payment and co-insurance in one benefit classification in one benefit package. And you will see that these questions truly follow the sequence of the parity regulations quite closely.

So let's say we have a co-payment of $10 for a primary care visit. Ten dollars is the level or the magnitude of the financial requirement, and primary care visit is the service to which the financial requirement is applied. The co-payment in this hypothetical example is applied the same way for primary care visits related to mental health or SUD, and for primary care visits related to medical surgical benefits.

So the user is able to answer yes to the next question, does this financial requirement apply to mental health SUD? Is it applied identically or less restrictive than the same FR applied to medical surgical benefits in the classification?

The user will then need to answer the following cell, which is a question about an explanation of how the FR is identical. So I'll copy over some example explanation here from our instructional guide. And you'll see when I selected yes, for this question, the rest of the questions actually gray out. And it is not

possible to answer the remaining questions in the set, so you'll see here that I get an error message if you attempt to answer that question.

I'll now show you what it looks like if you select no. So we'll go back to this example of a coinsurance. Again, we're in the same benefit package in the outpatient benefit classification. So let's say we have a 10% coinsurance for a specialty visit, 10% is the level or the magnitude of the financial requirement, and specialist visit is the service to which it is applied.

If the user selects no to this question, they do not need to fill out the accompanying explanation for why it is identical, so that's why this cell grays out if you select no. The user must then complete the remaining questions in the set, which are related to the substantially all
and predominant tests inherent to the Medicaid and CHIP parity regulation. These are further explained in the instructional guide.

We'll now move on to the NQTL worksheets. As noted, there are individual NQTL worksheets per highlighted and other NQTLs for each of the four benefit classifications that plans should address, even if it is to say that they are not applicable. So the user will complete the first question.

So for this example in prior authorization in the inpatient classification, is prior authorization applied to the inpatient benefit classification? In this hypothetical example we'll say the plan does apply prior authorization in the inpatient benefit classification. And then the user will need to enter in the applicable benefit packages in which prior authorization in
the inpatient benefit classification is applied. So we can say hypothetically that it's benefit packages one and two.

The next cell is a place for the plan to link or attach any supporting

documentation such as policy documents. These questions below, and the analysis questions, are intended to collect information from managed care plans and minimize rework for states. The state will then use all of this information to complete the NQTL comparative analyzes and make a compliance determination, which Tom will discuss in his demonstration of the state summary template.

This form may look familiar to many states. There are two columns per benefit package, one column from mental health side and one column from medical surge. And the benefit packages are listed across the top of the sheet.

This may not look too dissimilar from other NQTL comparative analysis that states may have been collecting from plans in the past. We also note that this worksheet may make it easier for plans that are delivering services in multiple states to provide information in a consistent and efficient manner.

So the template here is asking the plans to enter for each of mental health studies and for medical-surgical benefits for each benefit package the benefits to which the NQTL applies. So for this hypothetical example you could indicate inpatient psychiatric services in this column for mental health studies and then inpatient medical-surgical services under MS.

Then the plan will need to provide information about the strategies, evidentiary standards, processes, and other factors used in the design of or being applied to the NQTL as written and in operation for each of the mental health fund benefits and for MS benefits using the appropriate columns. I will now hand the demonstration off to Tom who will go through the state summary template in detail.

Tom Schenck: Thank you, Brooke. Okay, so I'm going to be going over the state summary

template, which is what the state will then use to document its analyzes of all the plan and fee-for-service program templates that it receives. This is a large template with multiple worksheets, however the template is embedded with conditional formatting and other functionality that is intended to streamline the analysis by limiting the number of worksheets in data fields that require data entry and to limit any duplication.

In the interest of time I am not going to go through each worksheet in detail. Please refer to the instructional guide for that granular level of information. Instead, I'm going to focus today's time on two things, number one, the worksheets and fields that are embedded with the most functionality. We want to make sure you understand how the template itself is intended to work so that you can have the proper vantage point to respond to the request for comment.

And number two, the NQTL portion of the template. The NQTL worksheets represent a new format for documenting and analyzing NQTLs, and we want to make sure its intent is properly conveyed. Before I begin the demonstration a few notes about the organization of the template itself.

Worksheets B through H are introductory worksheets, and set the parameters for the analysis you'll be doing later in the template. These include worksheets that correspond to a number of the steps outlined in the parity toolkit and that many states are currently following in their parity analyzes already, things like the definition of mental health, SUD, and med-surg in the state, and the mapping of benefits into the four benefit classifications.

Worksheets I through AA is where states will document the tests and analyzes required by the parity regulations. These include the same tests covered in the plan template, ALADLs, FRs, QTLs, and NQTLs. One thing you'll notice is

that some of these worksheets are the standard gray color, both in the table of contents and along the tabs, whereas most are color-coded.

Throughout this template tabs that are applicable only to Medicaid MCO program types are color-coded in green, tabs applicable only to separate CHIP programs are color-coded in orange, and tabs applicable only to ABP fee-for-service programs are color-coded in magenta. However, the few tabs that are gray are applicable to all program types. They must be completed in all submissions that they will collect information that is applicable across the entire state program.

I'm going to move into a template demonstration. Simply for illustrative purposes, all of the interactive data entry I will be doing today will be on the green colored worksheets that are applicable to the MCO program type data. The same concepts and functionality I discussed with these worksheets does apply to both the CHIP and ADP worksheets.

Very briefly, the first worksheet you'll encounter is Worksheet B, the Intro Data Worksheet. This is a simple worksheet where the state will enter things like contact info and the effective date. The thing I really want to point out here is that you do not need to enter anything in Table B1. This section will be auto-populated based on the entries you will make in the program type data worksheets, which I'm going to go through in detail right now.

The program type data worksheets are where the state is going to provide the detail on which benefit packages are offered, which delivery systems are being used, and which entities are delivering benefits. Again, when I say entity, I'm referring to either managed care plans or safety for service programs. It is critical that these worksheets be completed comprehensively and accurately for two reasons.

First, the information you provide here will provide a full understanding of which comparative analyzes the state has performed to assess parity, but secondly there is a lot of functionality built into
the program type data worksheets that is intended to simplify later portions of the analysis and reduce the amount of manual data entry throughout the template. I'm going to demonstrate this with a simple example.

So you'll see that this worksheet includes two tables, Step 1 and Step 2. Step 1 is where states will enter the benefit packages being offered and the delivery systems being used. So I'm just going to go ahead and enter
in benefit package one, under benefit package. And then I need to indicate the delivery system for mental health benefits, SUD, and med-surg within that benefit package.

So there's a drop-down menu that will appear allowing you to select that either benefits are delivered by a single MCO, fee-for-service, or some combination thereof. To keep things simple I'm just going to indicate that for mental health, SUD, and med-surg, all benefits are delivered by a single MCO.

Step 2, is where the state will describe which entities actually deliver the benefits in each benefit package. So first you'll go to the benefit package column and select The Benefit Package. You will see that the benefit package is entered in Step 1, auto-populate the drop-down menu in Step 2. So just to show this, if I were to go up and add benefit package two, go back down
here you would see that the drop-down menu would update.

Now, I'm going to enter the entity that's delivering mental health, SUD,
and med-surg respectively. And again, just to keep it simple, I'm going to put in MC01, MC01, and MC01. What I want to show you now is all the different

places where this information will auto-populate other fields and drop-down menus throughout the template.

First, going back to that intro data worksheet, you'll see that the information entered in program type data tabs will auto-populate this table so that when this template is finally submitted it will include a finalized consolidated overview of how benefits are delivered and how parity is being assessed for MCOs, CHIP, and separate and ABP fee-for-service depending on which programs are applicable in the state.

Secondly, moving over to the tab for benefit classification mapping, this is a step where states will list all their benefits, map them, and identify them as either mental health SUD or med-surg and map them into classifications. And you can see that the benefit packages that were entered into that program type data worksheet are now auto-populating this header row, and this will help you throughout this worksheet.

And then moving into the limits tabs for each of ALADL, FR, and QTL, you'll see that the benefit packages that you enter will also auto-populate the drop-down menus here. And you can just select one. And it will auto-populate all of the questions that need to be answered for that particular benefit package in the respective limit tabs.

Lastly, in the intro and QTL tab, there is actually a column for which entity provides mental health and SUD benefits. And that is auto-populated with the entities that you enter in the program type data worksheets. So, all of this is to say please take extra care to complete the program data type worksheet accurately, and it will make the rest of the template easier and much more intuitive.

So I'm not going to go through many of the other worksheets in detail just know that once you get through the introductory tabs, you will get to the regulatory tests. The ALADL, FR, and QTL worksheets function the same way as they do in the plan template that Brooke already showed.

I'll just reiterate what Brooke already showed you, which is that these yes, no questions in the All Limit Worksheet have the same functionality where they will gray out entire worksheets and indicate that they should be skipped based on how you respond to these questions. So this is another worksheet that is really important to pay attention to.

But rather than spend any more time on these worksheets we're going to spend the remainder of our time focused primarily on the NQTL portion of the analysis. The NQTL portion of the template is comprised of two worksheets. Before you get to the NQTL worksheet itself the state must complete what is called the Intro NQTL Worksheet.

Like the program type data tabs it is critical to complete the Intro NQTL tab correctly. The data entered by states in these worksheets will auto-populate data fields and limit or gray out the number of fields that require data entry in the actual NQTL worksheets.

Briefly, I'm just going to show you what the NQTL worksheet itself looks like before anything is entered in the Intro NQTL tab. This is where you will actually put the results of your NQTL parity analysis. But what you see here is that all the cells are grayed out, signifying that no data should be entered.

These cells will open up and turn white based on what you enter in the Intro NQTL worksheet. So the template is designed to ensure that the state is only asked and prompted to document its parity analysis for NQTLs and benefit

packages that are applicable within the state.

Now I'm going to go back to the intro NQTL worksheet to provide an overview. The Intro NQTL Worksheet includes two tables. Step one is pre-populated with the five highlighted NQTLs that Brooke mentioned, prior authorization, concurrent review, step therapy, or fail first, standards for provider network admission, and standards for providing access to other network providers.

Step two is where states can manually enter other NQTLs that might be applied by entities delivering benefits subject to parity. So if something like retrospective review were being applied, you could just enter it there and conduct the analysis.

So as noted earlier the entity drop-down is auto-populated with the information that the state provides in the respective program type data worksheets. This is because NQTL policies are often driven by the individual entities as opposed to the benefit packages, so different managed care plans might have their own utilization management program policies, et cetera.

So this is going to auto-populate allowing you to select MC01 or any other entity that has already been entered. And then you would move into the benefit package column. Benefit package is not auto-populated. This is because in the event an entity in your state applies identical NQTL policies across multiple benefit packages, you are able to manually enter the names of each benefit package.

So in a hypothetical scenario you could enter
in benefit package one and benefit package two, or if applicable you could simply enter all. Again, multiple benefit packages can only be entered for a

single entity if the entities and QTL policies are identical.

Now I'm going to move over to the benefit classification portion and select yes, no, or NA for each of the four benefit classifications. Given that this is prior authorization I'm going to say yes, it applies to inpatient, applies to outpatient, no for emergency care, and yes for prescription drugs.

Now that we have an example, let's move over and talk about how to actually complete the NQTL worksheet. The NQTL worksheet is where the state will document its analysis, and it will likely require the most significant level of effort in the template.

This is where the state is going to document the conclusions you have reached after reviewing the NQTL comparative analyzes of mental health SUD and med-surg that have been submitted to the state by managed care plans or the state fee-for-service program, and the worksheet is designed to structure that analysis as much as possible.

Before I walk through it I'm going to note that this worksheet is pre-populated with enough cells to capture all benefit packages that could potentially be entered in the intro NQTL worksheet, so it is a big worksheet. However, it is likely that most of these cells will not necessarily be used. For today's purposes, I'm going to filter on the benefit package column so that only those cells applicable to the MC01 all benefit packages entry from the intro NQTL worksheet are showing.

I would highly recommend that if you are playing around with this template as you're considering comments that you utilize the filters in this worksheet in particular to avoid a lot of scrolling. Looking at the columns you'll see there there's a pre-populated NQTL column, a pre-populated benefit

classification column, an auto-populated column for the entity and benefit package combination that is auto-populated with what you've entered in the Intro NQTL Worksheet, and then there is an instruction column.

And here you'll see detailed instructions about what you are being asked to do in each row. Importantly, in the header row in this worksheet you will see pre-populated examples of strategies, evidentiary standards, and processes. Moving forward, I am going to refer exclusively to strategies, but please know that anything I say also applies to evidentiary standards, processes, or other factors.

These pre-populated categories are intended to prompt states to respond to common strategies, but they are not intended to be an exhaustive list. States must enter a response for each of the pre-populated categories in the worksheet. However, if any of these strategies are not applicable, you can simply select not applicable from the drop-down menu, and we'll talk through these options a little more shortly.

Furthermore, states have the option to manually enter additional or other types of strategies either in this column here next to where it says other. You can simply go in and if prevent over-utilization were a strategy, you could enter that in and then document your analysis.

One last thing to note before I discuss the actual analysis is you will see that the emergency care cells for the all MCO entity benefit package combination are still grayed out. This is because we selected no in the Intro NQTL Worksheet, so these cells never opened up.

This is just a reminder to complete the benefit classifications accurately. You can envision scenarios of something like step therapy that may only apply to

outpatient or prescription drugs, or concurrent review that in some instances may only apply to inpatient. And this will gray out significant portions of the NQTL worksheet and will save you all significant time.

Okay, now to talk about what the state is actually being asked to do in this template. As I noted this worksheet is where the state will document the results of its assessment of the comparative analysis submitted by the entities delivering benefits subject to parity in the state. For each benefit classification within each NQTL, you are being asked to document the results of both a comparability analysis and a stringency analysis for each strategy being used in the design or application of the NQTL.

I'll go over the process for comparability, but the process is the same for the stringency portion. In the first row, the state is asked for its overall assessment of the strategy's comparability. You can see here that you are given four drop-down options, identical therefore comparable, comparable but not identical, not comparable, and not applicable.

I'll go through each of these beginning with not applicable. So not applicable is what the state will select if the pre-populated strategy is not used in the design or application of the NQTL. You will see that if not applicable is selected the other cells in the comparability analysis section will gray out and the state can move on to the stringency portion. Similarly, if you select identical therefore comparable, these same cells remain grayed out.

As stated in the instructional guide if you select this option the state is attesting that the strategy evidentiary standard, process, or other factor is identical in both writing and operation in its application to both mental health HUD and med-surg benefits. If there are even slight differences in how it's applied, this option should not be selected.

If the state has determined that the strategy is comparable, but not identical, this is where the state will be asked to provide the most narrative justification. As stated in the instructional guide, if this option is selected, the state must explain in this cell how the application of the strategy is different in mental health SUD compared to mid-surg, why it is different, why the state determined that it is comparable not withstanding those differences, and also explain how the differences do not adversely affect access to mental health and SUD benefits.

And then lastly, the last option is not comparable. And if this option is selected states are asked to describe the issue that led to a determination that the strategy is not comparable, and also to include an ID number from the issues for discussion worksheet, which we will actually be going over next, but quickly, you will follow this same process for documenting your stringency analysis.

And in this worksheet the state is being asked to document the results of its comparability and stringency analyzes for each strategy, evidentiary standard, process, or other factor used in the design or application of the NQTLs being applied in the state.

Okay, I'm not going to spend a lot of time on the issues for discussion tab, but I will just note that as a state completes its analysis of managed care plan and state fee-for-service documentation, it may notice potential parity issues. This includes situations in the NQTL worksheet where the state has made a determination of not comparable or more stringent.

But also throughout the ALADL, FR, and QTL worksheets, you'll see pop-up boxes that might prompt you to enter in something into the issues

for discussion worksheet depending on how you respond to certain questions. So this worksheet is where states will consolidate any findings that may cause concern for the Medicaid MCO, separate CHIP, and ABP fee-for-service program types, respectively.

The state is asked to identify in this worksheet, among other things, where the issue is located in the worksheet, you would select the tab, what the issue is, any actions that have been taken or are planned to be taken, as well as an expected resolution date. And then as the template is resubmitted over time, the state will be asked to update its entries and document an eventual resolution date. And I will note that there are separate issues for discussion worksheets for MCO separate CHIP and ABP fee-for-service, respectively.

So that is the end of the demonstration portion. I'll just reiterate that the state summary template asks states to comprehensively document their parity analyzes, but it does include functionality that is intended to streamline data entry and minimize duplication. In particular, as you're working through this, the program type data, All Limits, and Intro NQTL Worksheets are important to ensure that the template functions as intended.

However, please refer to the instructional guide for detailed explanations of how to use the template and/or if you run into issues while reviewing it. And I'll just reiterate, as Kirsten Beronio noted, that any formal comments that you'd like to make on the templates must be submitted to this email address, the medicaidandchip-parity@cms.hhs.gov by December 2, 2024.

Any comments submitted today through this call cannot be considered official submissions to the RFC. But with that I will pass it to Jackie Glaze for any questions.

Jackie Glaze: Thank you so much, Tom. I appreciate your demonstration. So we are ready to take state's questions at this time. And I do see that we already have some questions, so please continue to submit them through the chat function, and then we will follow by taking questions over the phone line. So I'll turn now to you, (Krista), to work through the questions.

(Krista): Thank you so much, Jackie. The first question here is, "Would the state summary template take the place of the required written parity report that is sent to CMS and posted on the Web site?"

Kirsten Beronio: So this is Kirsten Beronio. You know that is something that we are considering, and asking for comments on. So feel free to submit some comments on that question to the mailbox that Tom just went over.

(Krista): Thank you, Kirsten. Another question here is, "Will CMS provide standard training to users of the plan template that states can refer them to?"

Kirsten Beronio: Again, open to that as a comment, as a recommendation. This is a, you know, a very preliminary level. We're just developing these tools, trying to make sure that we've addressed all the issues we need to in terms of the regulations and requirements. And hoping to hear back from folks about whether, you know, this can be helpful in terms of training. You know, we will take that under advisement and think about that, but feel free to submit that in your comments as well.

(Krista): This next question is in a similar vein about training, "Will there be another tutorial next year closer to when we have to do this? We would love a refresher on these processes."

Kirsten Beronio: Yes, just to clarify this is open for comment, not yet final. So we

will - subsequent to gathering input through this process, as a preliminary round of input, then move to finalizing these templates if they seem to be helpful, and putting them through the Paperwork Reduction Act process which requires another round of public comment. So, you know, that will be kind of ongoing if we move forward with this into the new year, so it's too early to speak to some of the questions.

(Krista): Thanks, Kirsten. Another one here is, "In the Intro NQTL MCO tab, it looks like there were only rows for four MCOs, will the template let us add additional MCOs?"

Kirsten Beronio: I'm going to ask MITRE to respond. I think so, but MITRE, Tom, or (Chuck)?

Tom Schenck: Yes, so that is actually - I think there is a specific question about that in the RFC. You're right I think as of now there was only the four rows. I think we definitely recognize that there will oftentimes be more. The reason for that is that there's a lot of conditional formatting and formulas being built into the worksheet.

And we want to make sure that when we finalize these that it captures sort of the maximum or sort of a realistic maximum of the number of MCOs that might be in play. So that is why that is one of the specific questions asked for the RFC. But for this version here I think because it's preliminary, and meant for comment, it only included the four.

(Krista): Thank you. I think this next question might be related, "Is there a limit on how many NQTLs can be entered into the template?"

Kirsten Beronio: MITRE?

(Brooke): Yes, right now it's possible to enter the five high-rated NQTLs as well as five additional other NQTLs. So there's ten total, but we can also take that comment under advisement.

Tom Schenck: And I would also just note I don't - I didn't mention this when I went through it, that - so even though there is that second table in the Intro NQTL where you would enter in additional NQTLs, in that template, You would then attest that your analysis whether or not your analysis determined that these other NQTLs were - these other NQTLs applied comparably or no more stringently, the NQTL worksheet itself is at this time limited to the five highlighted NQTLs that were called out, but yes, thanks.

Jackie Glaze: Thank you, Tom. So I think we're ready to move now to the phone lines. So (Missy), if you could please provide instructions for registering questions and if you could open the phone lines.

Coordinator: Yes, ma'am. I'm If you would like to ask a question at this time, please press Star followed by 1. Please make sure that your phone is unmuted and record your name when prompted. If you wish to withdraw your question, you can press Star 2. Please allow a moment for questions to come in. Thank you. I'm not seeing any questions coming in yet, Jackie.

Jackie Glaze: Great, thank you. So if you could keep an eye - I think we did receive another question through the chat, so I'll turn to (Krista). And then you let me know, (Missy), if there are more questions coming through the phones.

Coordinator: Yes, ma'am.

Jackie Glaze: Thanks.

(Krista): Great. So one additional question here in the chat, "For the NQTL tab is it possible to report Medicaid and CHIP benefit NQTLs together in one tab?"

Tom Schenck: So there are separate worksheets for Medicaid MCO, CHIP, and ABP fee-for-service. One thing I will note, and this is described in some detail in the instructional guide, is if, in a hypothetical scenario, there were a health plan like Blue Cross Blue Shield that apply - that they deliver benefits in both Medicaid Managed Care and CHIP, and they apply the same NQTLs identically, there is a way in the template for you to indicate that so that your analysis for those identical NQTLs would only need to be entered once. And it would point the CMS reviewer to where that has been entered.

But an answer to the question of whether or not you would actually enter separate analyzes for managed care and CHIP in the same worksheet, no. They would go into separate worksheets. That's how it's set up.

Kirsten Beronio: Okay, thank you so much. I don't see any additional questions in the chat, but I do just want to share a comment. Thank you all for the wonderful tool and presentation. This is very exciting. I'm not sure if we have any on the phone lines, but no other questions in the chat.

Jackie Glaze: Thank you, (Krista). Any other phone - any other questions, (Missy)?

Coordinator: No, ma'am, there's not.

Jackie Glaze: Okay, so I think we'll go ahead and close out for the day. So I'd like to thank Kirsten, (Brooke), and Tom for their presentations. And I would like to remind everyone that next week we will have an ad hoc all state call on Thursday, excuse me, on Tuesday, October the 15th. And we'll continue our discussion on EPSDT.

So if you do have questions please bring those with you to the next call or reach out to us or your state lead. So we do thank you for joining us today, and we hope everyone has a great afternoon. Thank you.

Coordinator: Thank you, that does conclude today's conference. You may disconnect at this time. And thank you all for joining.

END