



Parity Compliance Toolkit Applying Mental Health and  
Substance Use Disorder Parity Requirements to Medicaid and  
Children's Health Insurance Programs

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# 1. Introduction to the Parity Compliance Toolkit

## 1.1 Parity Compliance Toolkit Overview

The purpose of this Parity Compliance Toolkit (Toolkit) is to provide detailed information and guidance to help states assess compliance with the final Medicaid/Children’s Health Insurance Program (CHIP) parity rule. A separate resource, the Parity Implementation Roadmap provides an operational resource to assist state policymakers in planning and organizing the parity work. This Toolkit focuses on the technical aspects of assessing parity compliance to assist in the implementation of the Medicaid/CHIP parity rule. Although this Toolkit includes guidance based on the Medicaid/CHIP parity rule, it is not a substitute for the rule, and states must comply with the final Medicaid/CHIP rule.

This Toolkit discusses and provides examples, tips, and key considerations on the following topics:

- General Parity Requirements and Approach to Determining Parity
- Defining Mental Health (MH) and Substance Use Disorder (SUD) Benefits
- Defining Classification and Mapping Benefits to Classifications
- Analysis of Financial Requirements (FRs), Quantitative Treatment Limitations (QTLs), and Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)
- Identifying and Analyzing Non-Quantitative Treatment Limitations (NQTLs)
- Parity Requirements for Medicaid Alternative Benefit Plans (ABPs)
- Parity Requirements for the Children’s Health Insurance Program (CHIP)
- Availability of Information Requirements

Please see section 10 for key abbreviations used in this Toolkit.

## 1.2 Parity Compliance Toolkit Highlights

Section 2 of this Toolkit reviews the general parity requirements (see section 2.1), summarizes the applicable parity requirements by program type (see Table 1), and outlines ten key steps in the parity analysis process (see section 2.2).

Section 3 of this Toolkit describes how to define MH/SUD benefits, including how the state must use a single generally recognized independent standard to determine which conditions are MH/SUD conditions and which are medical/surgical (M/S) conditions, and considerations for choosing a standard (see section 3.1). Section 3.2 highlights that it is the condition for which the item or service is provided that determines whether the item or service is defined as a MH/SUD or M/S benefit. Sections 3.3 and 3.4 describe example standards and factors to consider in the selection of a standard to determine which conditions are considered MH/SUD and which conditions are M/S conditions.

Section 4 of this Toolkit provides guidance on applying a reasonable standard to define the four benefit classifications: (1) inpatient, (2) outpatient, (3) prescription drugs, and (4) emergency

care. Section 4.2 provides an example of applying the requirement that MH and SUD benefits be provided in any classification in a benefit package in which M/S benefits are provided. Section 4.3 provides guidance and considerations in defining the classifications, and section 4.4 provides examples of how M/S and MH benefits (see table 3), and M/S and SUD benefits (see table 4), could be mapped to the four benefit classifications based on specified definitions.

Section 5 of this Toolkit provides information on how to analyze FRs, QTLs, and AL/ADLs to determine if they are compliant with parity. Section 5.1 outlines questions for state consideration in conducting this analysis. Section 5.2 describes the two-part test to determine parity compliance for FRs and QTLs, and provides examples (see table 5). Section 5.2.3 describes how to apply the two permissible sub-classifications of M/S and MH/SUD benefits: subdividing the outpatient classification into office visits and other outpatient (see tables 6 and 7); and prescription drug tiers. Section 5.2.4 addresses cumulative FRs and QTLs. Section 5.2.5 describes requirements for using and documenting a reasonable method to determine dollar amount of payments when testing FRs and QTLs. An example template for the two-part test for all FRs and QTLs where testing is necessary is provided in section 5.4. Section 5.3 provides guidance on how to conduct the cost analysis for AL/ADLs.

Section 6 of this Toolkit provides guidance on identifying and analyzing NQTLs for compliance with parity, beginning with definitions and examples of NQTLs (see section 6.1). Section 6.2 outlines the comparability and stringency requirements when applying an NQTL to MH/SUD benefits in writing and in operation. Section 6.3 provides examples illustrating NQTL analyses. Section 6.4 describes the requirement that a NQTL analysis be conducted for each type of NQTL that applies to MH/SUD benefits in a classification, not on a service-to-service basis, and provides a detailed example. Section 6.5 outlines the steps for conducting an NQTL analysis and provides examples. Section 6.6 provides examples and tips for identifying and analyzing NQTLs. Section 6.7 outlines the information necessary for conducting an NQTL analysis and provides two example tools for data collection (see NQTL Tool Development Examples A and B) along with considerations for each tool and examples of the types of questions an entity may address in responding to the example NQTL questionnaires.

Section 7 of this Toolkit provides guidance and tips on specific parity requirements for Medicaid ABPs. Regardless of whether a state provides ABP benefits through an MCO or FFS, certain parity requirements apply to the ABP. In addition, this section addresses how an ABP that provides Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is deemed compliant with parity requirements for the beneficiaries entitled to EPSDT benefits.

Section 8 of this Toolkit provides guidance and tips on parity requirements for CHIP, with specific information on Title XXI-funded Medicaid expansions (see section 8.1.1), separate child health plans (see section 8.1.2), and requirements for deemed compliance for separate child health plans that provide EPSDT (see section 8.1.2.1).

Section 9 of this Toolkit describes the two requirements regarding availability of information: (1) criteria for medical necessity determinations regarding MH/SUD benefits must be available to enrollees, potential enrollees, and contracting providers must be made available upon request and (2) reasons for any denial of reimbursement or payment for MH/SUD benefits must be made available to the beneficiary as they apply to Medicaid MCOs (see section 9.2), ABPs (see section 9.3), and CHIP (see section 9.4).

Section 10 of this Toolkit provides a list of key abbreviations.

## 2. General Parity Requirements and Approach to Determining Parity

### 2.1 Introduction

The final Medicaid/CHIP parity rule applies most provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to coverage provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Programs (CHIPs).<sup>1</sup> Parity requirements do not apply to mental health (MH) or substance use disorder (SUD) benefits for beneficiaries who receive only Medicaid non-ABP fee-for-service (FFS) state plan services. However, the Centers for Medicare & Medicaid Services (CMS) encourage states to comply with parity for all beneficiaries.

The final Medicaid/CHIP parity rule includes the following requirements:

1. Aggregate lifetime and annual dollar limits (AL/ADLs)
2. Financial requirements (FRs) and treatment limitations, which include—
  - a. FRs such as copayments, coinsurance, deductibles, and out-of-pocket maximums
  - b. Quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits
  - c. Non-quantitative treatment limitations (NQTLs) such as medical management standards, provider network admission standards and reimbursement rates, fail-first policies, and other limits on the scope or duration of benefits
3. Availability of information

The general parity requirement for AL/ADLs is that an AL/ADL cannot be applied to MH/SUD benefits unless it applies to at least one-third of medical/surgical (M/S) benefits. See section 5.3 of this Toolkit for additional information on the parity requirements for AL/ADLs.

The parity requirement for FRs and QTLs is as follows: An FR or QTL that applies to MH/SUD benefits within a classification may not be more restrictive than the predominant FR or QTL that applies to substantially all M/S benefits in that classification. See section 5.2 of this Toolkit for additional information on the parity requirements for FRs and QTLs.

The requirement for NQTLs is as follows: An NQTL may not apply to MH/SUD benefits in a classification unless, under the policies and procedures of the state, MCO, Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP), as written and in operation,

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<sup>1</sup> Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans. Federal Register; March 30, 2016. <https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>



any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification. See section 6.2 of this Toolkit for additional information on the parity requirements for NQTLs.

Parity does not mandate coverage of MH/SUD benefits. However, if coverage is provided for MH or SUD benefits in any classification, coverage for MH or SUD benefits must be provided in every classification in which M/S benefits are provided. The four benefit classifications for purposes of Medicaid and CHIP parity analyses are (1) inpatient, (2) outpatient, (3) prescription drugs, and (4) emergency care. See section 4.2 of this Toolkit for additional information on the requirements for coverage of MH/SUD benefits.

The requirements for availability of information are as follows:

- Criteria for medical necessity determinations regarding MH/SUD benefits must be made available to enrollees, potential enrollees, and contracting providers upon request
- The reasons for any denial of reimbursement or payment for MH/SUD benefits must be made available to the beneficiary

See section 9 of this Toolkit for additional information pertaining to the requirements for availability of information.

Regardless of whether a state provides ABP benefits through an MCO or FFS, certain parity requirements apply to the ABP. However, an ABP that provides Early and Periodic Screening, Diagnostic and Treatment (EPSDT), which is a requirement for all ABPs that include individuals under age 21 years, is deemed compliant with parity requirements for the beneficiaries entitled to EPSDT benefits. See section 7 of this Toolkit for additional information on requirements specific to ABPs.

Similar to ABPs, parity requirements apply to separate CHIPs regardless of delivery system. Separate CHIP programs that provide full EPSDT coverage that is compliant with EPSDT requirements under Medicaid are deemed compliant with parity requirements. See section 8 of this Toolkit for additional information on special requirements for CHIPs.

Table 1 summarizes the applicable parity requirements by program type, including Medicaid MCO, ABP for beneficiaries under age 21 years, ABP for beneficiaries aged 21 years and over, CHIP Medicaid expansion, separate CHIP without EPSDT coverage, and separate CHIP with EPSDT coverage.

**Table 1. Parity Requirement by Program Type<sup>a</sup>**

Parity Requirements	Program Type Affected by Parity Requirement					
	Coverage to Enrollees in a Medicaid MCO <sup>b</sup>	ABP <sup>c</sup>		CHIP		
		Under Age 21 Years (i.e., Providing EPSDT) <sup>d</sup>	Aged 21 Years and Older	CHIP-Related Medicaid Expansion <sup>e</sup>	Separate CHIP Without EPSDT	Separate CHIP With EPSDT
Deemed compliance with mental health and SUD parity on the basis of providing fully compliant EPSDT  (42 CFR § 440.395(c) (42 CFR § 457.496(b))		✓				✓  <b>Note:</b> Some states provide EPSDT only to some portion of their separate CHIP populations. In addition, some states report the provision of EPSDT but may not provide in accordance with statutory requirements, which is required for deeming (sections 1905(r) and 1902(a)(43) of the Act).
Annual and Lifetime Dollar Limits  (42 CFR § 438.905) (42 CFR § 457.496(c))	✓	<b>Note:</b> AL/ADLs are prohibited for EHBs (see 1937(b)(5) of the SSA and 42 USC 300gg-11)	<b>Note:</b> AL/ADLs are prohibited for EHBs (see 1937(b)(5) of the SSA and 42 USC 300gg-11)	✓	✓  <b>Note:</b> Used more commonly in CHIP compared with Medicaid, particularly higher income bands	<b>Note:</b> Must comply with Medicaid EPSDT statutory requirements

Parity Requirements	Program Type Affected by Parity Requirement					
	Coverage to Enrollees in a Medicaid MCO <sup>b</sup>	ABP <sup>c</sup>		CHIP		
		Under Age 21 Years (i.e., Providing EPSDT) <sup>d</sup>	Aged 21 Years and Older	CHIP-Related Medicaid Expansion <sup>e</sup>	Separate CHIP Without EPSDT	Separate CHIP With EPSDT
Financial Requirements and Quantitative Treatment Limitations  (42 CFR § 438.910(a),(b),(c)) (42 CFR § 440(b)(1), b(2) b(3)) (42 CFR § 457.496(d)(1), d(2), d(3))	✓	Deemed compliant	✓	✓	✓ <b>Note:</b> Financial requirements are more common in CHIP compared with Medicaid, and it is common for FRs to increase as beneficiary income increases	<b>Note:</b> Must comply with Medicaid EPSDT statutory requirements
Non-Quantitative Treatment Limitations  (42 CFR § 438.910(d)) (42 CFR § 440.395(b)(4)) (42 CFR § 457.496(d)(4))	✓	Deemed compliant	✓	✓	✓	<b>Note:</b> Must comply with Medicaid EPSDT statutory requirements
Availability of Plan Information  (42 CFR § 438.915) (42 CFR § 440.395(d)) (42 CFR § 457.496(e))	✓		✓	✓	✓	
State Posting of Documentation of Compliance  (42 CFR § 438.920(b))	✓	✓ <b>Note:</b> Only if using MCO	✓ <b>Note:</b> Only if using MCO	✓ <b>Note:</b> Only if using MCO		

Parity Requirements	Program Type Affected by Parity Requirement					
	Coverage to Enrollees in a Medicaid MCO <sup>b</sup>	ABP <sup>c</sup>		CHIP		
		Under Age 21 Years (i.e., Providing EPSDT) <sup>d</sup>	Aged 21 Years and Older	CHIP-Related Medicaid Expansion <sup>e</sup>	Separate CHIP Without EPSDT	Separate CHIP With EPSDT
(42 CFR § 440.395(e))		delivery system	delivery system	delivery system		
Clarifying Standards for Defining Benefits (42 CFR §438.900) (42 CFR §440.395) (42 CFR §457.496(a))	✓	✓	✓	✓	✓ <b>Note:</b> Under 42 CFR § 457.496(f)(1) (i), states must indicate in the state plan which standard is used	✓

Abbreviations: ABP, alternative benefit plan; AL/ADL, aggregate lifetime and annual dollar limit; CHIP, Children’s Health Insurance Program; EHBs, essential health benefits; EPSDT, Early and Periodic Screening, Diagnostic and Treatment; FR, financial requirement; MCO, managed care organization; NQTL, non-quantitative treatment limitation; SSA, Social Security Act; SUD, substance use disorder.

<sup>a</sup>The parity requirements vary by program type because different statutory provisions apply to Medicaid MCOs (section 1932(b)(8) of the SSA), ABPs (section 1937(b)(6) of the SSA), and CHIP (section 2103(c)(6) of the SSA).

<sup>b</sup>When a Prepaid Inpatient Health Plan, Prepaid Ambulatory Health Plan, or state fee-for-service delivery system also is used to provide benefits to an enrollee of a Medicaid MCO, the parity standards apply to and take into account those benefits under the separate delivery mechanism(s). See 42 CFR §438.920.

<sup>c</sup>Parity requirements apply to ABPs regardless of delivery system.

<sup>d</sup>EPSDT is a required benefit for Medicaid beneficiaries under the age of 21 years.

<sup>e</sup>The requirements applicable to CHIP Medicaid Expansions programs are the same as the requirements applied to the Medicaid program.

## 2.2 Key Steps in the Parity Analysis Process

The key steps in the parity analysis process are as follows:

1. Identify all benefit packages to which parity applies (including all benefits provided to MCO enrollees, regardless of authority, and benefits in FFS ABP and separate CHIPs). A benefit package includes all benefits provided to a specific population group (e.g., children, adults, individuals with a nursing facility level of care) regardless of delivery system.
2. For each benefit package, determine whether the state or an MCO is responsible for the parity analysis. If an MCO is responsible for the parity analysis, the state should ensure that the MCO contract includes applicable requirements for the MCO to perform the parity analysis.
3. Determine which covered benefits are MH/SUD benefits and which are M/S benefits (see section 3 of this Toolkit).
4. Define the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and determine into which benefit classification MH/SUD and M/S benefits fall (see section 4 of this Toolkit).
5. Identify and test each AL/ADL applied to MH/SUD benefits for compliance with applicable parity requirements (see section 5 of this Toolkit).
6. Identify and test each FR and QTL applied to MH/SUD benefits in a classification, by benefit package, for compliance with applicable parity requirements (see section 5 of this Toolkit).
7. Identify and test each NQTL applied to MH/SUD benefits in a classification, by benefit package, for compliance with applicable parity requirements (see section 6 of this Toolkit).
8. Assess compliance with requirements regarding availability of information (see section 9 of this Toolkit).
9. On the state's website, document and post findings from the parity analysis, including any follow-up activities, applicable to the benefits provided to enrollees of MCOs.
10. Implement any changes needed to the Medicaid state plan, ABP state plan, child health plan, MCO/PIHP/PAHP contract, MCO/PIHP/PAHP rates, state policies and procedures, MCO/PIHP/PAHP policies and procedures, and so forth, in order to meet parity requirements by the applicable compliance date.

In addition to completing the parity analysis, the state and its contractors should implement monitoring procedures to ensure continued compliance and to identify when changes in benefit design or operations could affect compliance and require an updated analysis.

### **3. Defining Mental Health and Substance Use Disorder (MH/SUD) Benefits**

#### **3.1 Defining MH/SUD Benefits Is a Prerequisite for Determining Parity**

In order to determine whether MH/SUD benefits are provided in parity with M/S benefits, the state must identify which benefits are considered MH/SUD benefits and which are M/S benefits. As defined in Table 2, MH/SUD benefits are benefits for items and services for MH/SUD conditions and M/S benefits are benefits for items and services for medical conditions or surgical procedures.

The federal statute and regulations do not identify specific conditions as MH/SUD or M/S conditions; instead, states must look to “generally recognized independent standards of current medical practice” for defining benefits. The state must choose a specific standard for identifying and defining which conditions are considered MH/SUD conditions and which are considered M/S conditions, so that services are categorized and classified consistently and all parity analyses are conducted consistently. A state cannot define conditions using different standards, and a state cannot pick and choose conditions within a standard. However, a state may use the structure of the manual to identify which conditions are MH/SUD conditions (e.g., specified chapters or sections). A state must use a single standard to determine which conditions are MH/SUD and which are M/S conditions, but the choice of the generally recognized, independent standard is up to the state. As further discussed in section 8, for separate CHIPs that do not provide full coverage of EPSDT, the state must identify the standard for defining MH/SUD and M/S benefits in its child health plan.

When looking at different standards for defining MH/SUD conditions, states should consider the following questions:

- Has the state already used certain generally recognized national standards of current medical practice to define MH/SUD conditions?
- Which benefits for items and services must be considered MH/SUD benefits on the basis of the selected standard?
- As a best practice, how does the state ensure that the same standard applies to all Medicaid or CHIP benefits covered for MCO enrollees, ABP beneficiaries, and CHIP beneficiaries?

#### **3.2 Definition of MH/SUD and M/S Benefits Is Based on the Condition for Which the Item or Service Is Provided**

The final regulations include as examples of generally recognized independent standards of current medical practice for defining MH/SUD benefits the most current version of the

*Diagnostic and Statistical Manual of Mental Disorders* (DSM),<sup>2</sup> the most current version of the International Classification of Diseases (ICD), and state guidelines. Because these are examples, states may use other standards.

Final parity regulations provide the definitions for MH, SUD, and M/S benefits contained in Table 2.

**Table 2. Definitions of Mental Health, Substance Use Disorder, and Medical/Surgical Benefits**

Mental Health/Substance Use Disorder Benefits	Medical/Surgical Benefits
<p><i>Mental health benefits</i><sup>a</sup> means benefits for items or services for mental health conditions, as defined—</p> <ul style="list-style-type: none"> <li>• By the state and in accordance with applicable federal and state law. (Medicaid MCOs)</li> <li>• By the state under the terms of the ABP and in accordance with federal and state law. (ABPs)</li> <li>• Under the terms of a state plan in accordance with applicable federal and state law, and consistent with generally recognized independent standards of current medical practice. (CHIPs)</li> </ul> <p>Any condition defined by the state as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines). Mental health benefits include long term care services. (Medicaid MCOs and ABPs)<sup>b</sup></p>	<p><i>Medical/surgical benefits</i><sup>c</sup> means benefits for items or services for medical conditions or surgical procedures, as defined by the state and in accordance with applicable federal and state law but do<sup>d</sup> not include mental health or substance use disorder benefits. Any condition defined by the state as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the ICD or state guidelines). Medical/surgical benefits include long term care services. (Medicaid MCOs and ABPs)</p>
<p><i>Substance use disorder</i> benefits means benefits for items or services for substance use disorders,<sup>e</sup> as defined:</p> <ul style="list-style-type: none"> <li>• By the state and in accordance with applicable federal and state law. (Medicaid MCOs)</li> <li>• By the state under the terms of the ABP and in accordance with federal and state law. (ABPs)</li> <li>• Under the terms of the state plan in accordance with applicable federal and state law, and consistent with generally recognized independent standards of current medical practice. (CHIPs)</li> </ul>	

<sup>2</sup> American Psychiatric Association, American Psychiatric Association DSM-V Task Force. *Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition: DSM-V*. Washington, DC: American Psychiatric Association; 2013.

Mental Health/Substance Use Disorder Benefits	Medical/Surgical Benefits
<p>Any disorder defined by the state as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines). Substance use disorder benefits include long term care services. (Medicaid MCOs and ABPs)<sup>f</sup></p>	

Abbreviations: ABP, alternative benefit plan; CHIP, Children’s Health Insurance Program; DSM, Diagnostic and Statistical Manual of Mental Disorders; ICD, International Classification of Diseases; MCO, managed care organization.

<sup>a</sup> The CHIP definition of *mental health benefits* says that it means items or services “that treat or otherwise address” mental health conditions instead of “for” mental health conditions as in the rule that applies to coverage provided to MCO enrollees and ABP coverage.

<sup>b</sup> The CHIP definition does not include this paragraph and instead says, “Standards of current medical practice can be based on the most current version of the DSM, the most current version of the ICD, or generally applicable State guidelines. The term includes long term care services.”

<sup>c</sup> The ABP definition of *medical/surgical benefits* is the same except that it says, “as defined by the State under the terms of the ABP” instead of “by the State.” The CHIP definition of *medical/surgical benefits* is the same except that it says as defined, “under the terms of the State plan” instead of “by the State.” It also provides as an example of independent standards “generally applicable State guidelines,” instead of “State guidelines.”

<sup>d</sup> The ABP and CHIP definitions use the word *does* instead of the word *do*.

<sup>e</sup> The ABP and CHIP definitions use the word *disorder* instead of the word *disorders*.

<sup>f</sup> The CHIP definition does not include this paragraph and instead says, “Standards of current medical practice can be based on the most current version of the DSM, the most current version of the ICD, or generally applicable State guidelines. The term includes long term care services.”

MH benefits are defined as benefits for items and services for *mental health conditions* (similarly, SUD benefits are defined as benefits for items and services for *substance use disorders*).

*Example:* State Y has identified the DSM-V as the basis for defining benefits as MH/SUD and therefore defines anorexia as a mental health condition for purposes of parity compliance. Therefore, state Y must treat nutritional counseling as a mental health benefit when it is delivered for treatment of anorexia, regardless of the nature of the service or the provider delivering the service.

**Tip 3a:** When defining long term services and supports (LTSS) benefits in Medicaid and CHIP programs, it is the condition for which the service is provided that determines whether a service is an M/S or MH/SUD benefit. If a service is provided for an MH/SUD condition, the service is an MH/SUD benefit subject to parity. If the service is for an M/S condition, the service is an M/S benefit.



*Example:* State H covers personal care services for MCO enrollees. Personal care services provided for a M/S condition, for example, cerebral palsy are M/S services. Personal care services provided for an MH/SUD condition, for example, major depression, are MH/SUD benefits.

### 3.3 Standards Identified in the Final Regulation to Identify MH/SUD and M/S Conditions

A state may look to the examples in the final regulation for generally recognized independent standards of current medical practice to define MH/SUD and M/S conditions. Selecting the independent standard for definitional purposes raises factors that the state should consider, as noted in the discussion below.

#### 3.3.1 Diagnostic and Statistical Manual of Mental Disorders (DSM)

The DSM is published by the American Psychiatric Association and is designed primarily to assist trained clinicians in the diagnosis of MH/SUD conditions. The DSM includes the most commonly known MH/SUD conditions (such as depression or schizophrenia), and the fifth edition (DSM-V) also includes conditions such as the following:

- Neurodevelopmental disorders, which include attention deficit/hyperactivity disorder (ADHD), intellectual disabilities, and specific learning disorders
- Neurocognitive disorders, including neurocognitive disorders due to Alzheimer’s disease, traumatic brain injury, and Parkinson’s disease
- Sleep-wake disorders, including sleep apnea

*Tip 3b:* If a state deems all conditions listed in the most current version of the DSM to be MH/SUD conditions, certain items and services that states, MCOs, PIHPs, and PAHPs may not have previously defined as MH/SUD benefits may be defined as MH/SUD benefits for parity purposes. For example, the DSM-V includes Medication-Induced Movement Disorders and V-Codes (e.g., psychosocial and environmental circumstances that may be a focus of clinical attention), but the introduction to each chapter states that the conditions listed in the chapter are not mental disorders. Alternatively, a state may elect to apply the structure of the DSM to identify those conditions listed in the Medication-Induced Movement Disorders and V-Code chapters as M/S disorders.

*Example:* State Y determined that all conditions listed in the DSM-V are MH/SUD conditions, except conditions in the Medication-Induced Movement Disorders chapter, which are considered M/S conditions for the purposes of the parity analysis.

*Example:* State Z determined that all conditions listed in the DSM-V are MH/SUD conditions, except for V-codes (psychosocial or environmental factors that that may be a focus of clinical attention), which are considered M/S conditions for purposes of parity requirements.

As an independent standard that is utilized by many clinicians nationally, the DSM often is the standard selected by employers and used to determine which conditions are MH/SUD conditions for the federal and state private insurance parity laws. As a result, using the DSM for Medicaid and CHIP might provide a useful approach for consistent treatment of MH/SUD across all health coverage in a state, including Medicaid and CHIP.

Because the DSM is not a coding manual, if using the DSM as the standard, states will need to identify the MH/SUD conditions in the DSM-V and map them to procedure codes (i.e., ICD-10-Clinical Modification/Procedure Classification System [CM/PCS] codes) to perform any claims-based analyses needed to ensure parity compliance for QTLs, FRs, and/or ADLs.

*Tip 3c:* States choosing the DSM as the standard will need to factor in the time and expense to implement the code mapping necessary for claims processing purposes if claims are processed using ICD codes.

### *3.3.2 International Classification of Diseases (ICD)*

The ICD is based on the World Health Organization’s manual of international classification of diseases and is published by the American Medical Association. The ICD is used primarily for medical coding purposes. The ICD is a classification of diseases with codes and descriptors arranged within a tabular list of diseases. The most recent version of the ICD, the ICD-10, has 21 chapters—each based on the affected body system or the nature of the injury and disease. Unlike the DSM-V, the ICD-10 has a separate chapter that lists MH/SUD conditions: Chapter 5 “Mental, Behavioral and Neurodevelopmental Disorders (F01-F99),” making the identification of MH/SUD conditions in the manual an easier task. Because the ICD-10 is commonly used for claims processing, no additional mapping is necessary for claims payment purposes when claims using ICD-10 coding are used.

*Tip 3d:* Most claims processing systems currently use ICD codes; thus, choosing the ICD could make it easier to assess and implement parity.

### *3.3.3 State Guidelines*

A state can look to its own set of guidelines to define MH/SUD benefits if the state guidelines are based on generally recognized independent standards of current medical practice.

## *3.4 Other Standards States Can Use That Are Not Identified in the Final Rule*

Another generally recognized independent standard of current medical practice that a state could consider is the *Merck Manual*,<sup>3</sup> a widely used medical resource and textbook for professionals. The *Manual* is the product of a collaboration of medical experts, an independent editorial board of peer reviewers, and Merck’s editorial staff of physicians and professional medical writers. To ensure absence of commercial or corporate bias, authors and peer reviewers cannot be employees of Merck, nor can they serve as speakers for Merck or Merck Sharp & Dohme products, or in

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<sup>3</sup> Porter RS, ed-in-chief. *The Merck Manual of Diagnosis and Therapy*, 19<sup>th</sup> edition. Wiley; 2011.

any other way represent the company. The *Manual* is divided into Medical Topics and Subtopics, including Psychiatric Disorders. This makes it easier to separately identify MH/SUD and M/S conditions. Merck is not a coding manual, however, so mapping of MH/SUD conditions to ICD codes may be necessary for claims processing.

*Tip 3e*: In selecting a generally recognized standard to define MH/SUD and M/S benefits, states might want to consider how the standard aligns with the standard used by the state for parity compliance in the commercial insurance market. Although not required by the final Medicaid/CHIP parity rule, consistency of the definitions of MH/SUD and M/S benefits could be useful if the state contracts with commercial insurers to provide benefits to Medicaid/CHIP beneficiaries.

## 4. Defining Classifications and Mapping Benefits to Classifications

### 4.1 Introduction

The final regulations specify that requirements for FRs and treatment limitations apply by benefit classification. This section of the Toolkit is designed to provide guidance on establishing the four classifications of benefits.

To conduct a parity analysis, each M/S and MH/SUD benefit must be mapped to one of four classifications of benefits: (1) inpatient, (2) outpatient, (3) prescription drugs, or (4) emergency care.

### 4.2 Coverage in All Classifications

When MH or SUD benefits are provided in any one classification in a benefit package, then MH or SUD benefits also must be provided in every classification in which M/S benefits are provided for that benefit package.

*Example:* State X, which provides M/S, MH, and SUD benefits to Medicaid MCO enrollees, covers inpatient M/S and MH services but does not cover any inpatient SUD services. Consistent with the parity requirement for SUD benefits to be provided in every classification in which M/S benefits are provided, state X also must provide Medicaid benefits for inpatient SUD services.

### 4.3 Defining Each Classification

The applicable regulated entity (i.e., the MCO or state) must assign each service to one of four classifications identified in the regulation. In defining what benefits are included in a particular classification, the state or MCO must apply the same reasonable standard to M/S and MH/SUD benefits. A state may not assign M/S and MH/SUD benefits to a classification solely for the purpose of ensuring that certain FRs or treatment limitations will be applicable to the benefits. This is because it is not a reasonable standard for defining a classification or classifying a specific benefit to do so only to permit specific FRs and treatment limitations.

*Example:* If a state defines M/S inpatient benefits to include all benefits provided in a hospital setting (excluding, e.g., skilled nursing), that state may not define the MH/SUD inpatient benefits that it covers to include all benefits provided in any facility. This is because M/S inpatient benefits are defined as only those benefits that are provided in a hospital, and the *same* reasonable standard must be consistently applied to M/S and MH/SUD benefits.

In order to promote consistency for beneficiaries who may move from one benefit package to another, CMS encourages the state, MCOs, PIHPs, or PAHPs to define the classifications in the same manner across benefit packages. States may wish to include definitions of inpatient, outpatient, prescription drug, and emergency care in their MCO, PIHP, and PAHP contracts to ensure consistency across managed care entities in the state.

*Example:* If M/S and MH/SUD inpatient benefits for Medicaid beneficiaries are defined as those benefits requiring an overnight stay in a hospital, it is recommended, but not required, that the state define M/S and MH/SUD inpatient benefits for CHIP beneficiaries as benefits requiring an overnight stay in a hospital, even though the benefit packages may differ.

When defining classifications, the following questions should be kept in mind:

- How does the state, MCO, PIHP, or PAHP currently define these benefit classifications?
- Taking applicable law and benefit structure into consideration, what are some potential options for defining the classifications?
- For each of the options under consideration, what are the implications for the permissibility of MH/SUD financial requirements and treatment limitations in each classification?

#### 4.4 Illustrative Examples of Defining Classifications and Mapping Benefits

There are many options for determining how to assign benefits to classifications. Examples include defining classifications consistent with how services are billed (e.g., services billed as institutional claims are defined as inpatient<sup>4</sup>), on the basis of the setting in which services are delivered (e.g., services delivered during an overnight stay at a hospital are defined as inpatient) or according to the purpose of the service (e.g., facility-based services designed to avoid institutionalization are defined as inpatient).

Tables 3 and 4 contain examples<sup>5</sup> of how M/S and MH benefits, and M/S and SUD benefits, respectively, could be mapped to the four classifications if a state applied the following reasonable standards to define M/S, MH, and SUD benefits for its benefit packages. In this example, benefits are categorized in the following ways:

- **Inpatient:** All covered services or items provided to a beneficiary when a physician has written an order for admission to a facility.
- **Outpatient:** All covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care.
- **Prescription Drugs:** Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.

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<sup>4</sup> Claims submitted on the UB-04 form (electronic 837-I).

<sup>5</sup> The tables are samples only and not required forms. Listed services are included for illustrative purposes only and are not an exhaustive list.

- Emergency Care: All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting.

**Table 3. Example Mapping Medical/Surgical and Mental Health Benefits (including intermediate and LTSS) to the Four Classifications**

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
M/S	<ul style="list-style-type: none"> <li>• Surgery</li> <li>• Anesthesia</li> <li>• Semiprivate room</li> <li>• Medication administered during the admission</li> <li>• Lab</li> <li>• Radiology</li> </ul>	<ul style="list-style-type: none"> <li>• Preventive services</li> <li>• Primary care visit</li> <li>• Home-based nursing</li> <li>• Medication administered during the outpatient visit</li> <li>• Lab</li> <li>• Radiology</li> <li>• Personal care provided in the beneficiary's home</li> </ul>	<ul style="list-style-type: none"> <li>• Generic and name brand medications</li> <li>• Prescription medication required prior to a radiology study</li> </ul>	<ul style="list-style-type: none"> <li>• Ambulance</li> <li>• Consultation delivered in an ED</li> <li>• Medications administered during an ED visit</li> <li>• Lab</li> <li>• Radiology provided in an ED</li> </ul>
MH	<ul style="list-style-type: none"> <li>• Psychiatric services</li> <li>• Psychotropic medication</li> <li>• Respite</li> <li>• Peer support</li> </ul>	<ul style="list-style-type: none"> <li>• Psychotherapy</li> <li>• Rehabilitation services</li> <li>• Respite</li> <li>• Peer support</li> <li>• Parent training</li> <li>• Personal care provided in the beneficiary's home</li> </ul>	<ul style="list-style-type: none"> <li>• Generic and name brand medications (e.g., SSRIs, antipsychotics)</li> </ul>	<ul style="list-style-type: none"> <li>• Crisis stabilization</li> <li>• Psychotropic medication administered in an ED</li> <li>• Emergency respite</li> <li>• Peer support</li> </ul>

Abbreviations: ED, emergency department; LTSS, long term services and supports; MH, mental health; M/S, medical/surgical; SSRI, selective serotonin reuptake inhibitor.

The same standards for classifying benefits must be applied to all M/S and MH/SUD benefits, including intermediate services and LTSS. Applying these standards may mean that a service is both an M/S benefit and an MH or SUD benefit (e.g., respite care) or mapped to more than one classification. In this example, overnight respite services delivered in a hospital setting that require a physician's order for admission would be classified as inpatient benefits.

Nonemergency respite services delivered in a beneficiary's home would be assigned to the outpatient classification because the respite services are delivered in a setting that does not require a physician's admission order. Emergency respite services provided outside of an

inpatient setting to stabilize a crisis would be assigned to the emergency care classification, according to the criteria used in this example.

**Table 4. Example of Mapping Medical/Surgical and Substance Use Disorder Benefits to the Four Classifications**

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
M/S	<ul style="list-style-type: none"> <li>• Surgery</li> <li>• Skilled nursing care</li> <li>• Detoxification</li> <li>• Semiprivate room</li> <li>• Methadone when ordered by a physician in a hospital for pain</li> <li>• Lab</li> <li>• Radiology</li> </ul>	<ul style="list-style-type: none"> <li>• Preventive services</li> <li>• Primary care visit</li> <li>• Detoxification</li> <li>• Home-based nursing</li> <li>• Medication administered during the outpatient visit</li> <li>• Lab</li> <li>• Radiology</li> </ul>	<ul style="list-style-type: none"> <li>• Generic and name brand medications</li> <li>• Schedule II drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Ambulance</li> <li>• Consultation delivered in an ED</li> <li>• Medications administered during an ED visit</li> <li>• Lab</li> <li>• Radiology provided in an ED</li> </ul>
SUD	<ul style="list-style-type: none"> <li>• Acute psychiatric services</li> <li>• Residential SUD services</li> <li>• Detoxification in combination with treatment for a SUD</li> <li>• Buprenorphine when prescribed by a certified physician in a hospital</li> <li>• Methadone when ordered by a physician in a hospital for SUD</li> </ul>	<ul style="list-style-type: none"> <li>• Community-based detoxification</li> <li>• Intensive Outpatient Program Services</li> <li>• Federally certified OTP services</li> <li>• Methadone when delivered through an OTP</li> <li>• Counseling and behavior therapy (required for buprenorphine)</li> <li>• Psychosocial rehab</li> </ul>	<ul style="list-style-type: none"> <li>• Generic and name brand medications</li> <li>• Nicotine replacement and smoking cessation drugs</li> <li>• Buprenorphine when prescribed by a certified clinician and combined with counseling and behavior therapy in an outpatient setting</li> </ul>	<ul style="list-style-type: none"> <li>• Crisis stabilization services</li> <li>• Naloxone</li> </ul>

Abbreviations: ED, emergency department; MH, mental health; M/S, medical surgical; OTP, opioid treatment program; SUD, substance use disorder.

*Tip 4a:* Components of some covered benefits or programs may be assigned to multiple classifications. For example, Medication-Assisted Treatment (MAT) for opioid treatment includes medications (e.g., buprenorphine or methadone) and counseling and behavior therapy. Applying the definitions for the benefit classifications from the example above, buprenorphine (when ordered by a certified physician and combined with counseling and behavior therapy) and methadone, are inpatient benefits when provided in a facility that requires a physician’s order for

admission. Buprenorphine is a prescription drug benefit when *prescribed* by a certified physician in a setting that does not require a physician's admission order. The counseling and behavior therapy that is required for a beneficiary to receive buprenorphine is classified as an outpatient benefit when provided in setting that does not require a physician's admission order. Methadone, however, is an outpatient benefit when *dispensed* through an Opioid Treatment Program because no prescription is written separately for the medication, which would be required for the medication to be included in the prescription drugs classification.

*Tip 4b:* As illustrated above, the standard for defining a classification should address the assignment of benefits that may fit into multiple classifications (e.g., lab and radiology may be inpatient, outpatient, or emergency care depending on whether they are provided to a beneficiary during an inpatient stay, on an outpatient basis, or in an ED). It may be necessary to distinguish dollars paid for these M/S services in each classification for purposes of applying the FRs and QTLs analysis.

Once the four classifications are defined and all M/S and MH/SUD benefits are mapped to a classification, a state will be able to identify the range of permissible financial requirements, QTLs, and NQTLs that may be applied to specific MH/SUD benefits in each classification.



## 5. Analysis of Financial Requirements, Quantitative Treatment Limitations, and Aggregate Lifetime and Annual Dollar Limits

### 5.1 Introduction

States, MCOs, PIHPs, and PAHPs must evaluate financial requirements and quantitative treatment limitations on MH/SUD benefits to make sure that they are no more restrictive than those that apply to M/S benefits in the same classification. Any aggregate lifetime and annual dollar limits also must be evaluated for compliance with parity requirements.

Final regulations that apply MHPAEA requirements to Medicaid and CHIP require that states (or the MCO, if the MCO is conducting the parity analysis) perform an analysis of limits on MH/SUD benefits that involve the following:

- Financial requirements—Payment by beneficiaries for services received that are in addition to payments made by the state, MCO, PIHP, or PAHP for those services. This includes copayments, coinsurance, and deductibles.
- Quantitative treatment limitations—Limits on the scope or duration of a benefit that are expressed numerically. This includes day or visit limits.
- Aggregate lifetime or annual dollar limits—Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.

This analysis requires an assessment of the total costs of M/S coverage (which maybe require a review of claims data) in each classification to determine which FRs or QTLs apply to two-thirds of benefits in each classification or to what percentage of M/S benefits AL/ADLs apply. This section of the Toolkit is designed to provide information on (1) the specific tests in the regulation for these three types of limits and (2) how the cost analysis works for each of these three limits—including guidance on how to identify the FRs, QTLs, and AL/ADLs that require testing and guidance on what information can and should be collected to assess compliance. The FRs, QTLs, and AL/ADLs must be evaluated separately for each benefit package.

In conducting the analyses, states should keep the following questions in mind:

- For each benefit package, are there any FRs, QTLs, or AL/ADLs applied to any of the MH/SUD benefits? (This question must be answered for each classification of benefits.)
- If so, are there FRs, QTLs, or AL/ADLs on the M/S benefits in the benefit package? (This question must be answered for each classification of benefits.)
- If yes, is it possible to determine the results of the two-part test for FRs and QTLs without performing a more in-depth cost analysis? Is it possible to determine the results of the AL/ADLs test without performing a more in-depth cost analysis?

- How will the state go about conducting more in-depth cost analyses, including the methodology and data needed to estimate expected dollar payments for the analysis of each FR, QTL, and AL/ADL?
- What information should be collected, and how often must this information be collected to assess compliance?

## 5.2 The Two-Part Test for Financial Requirements (FRs) and Quantitative Treatment Limitations (QTLs)

The general Medicaid and CHIP parity rule is that no FR or QTL may apply to MH/SUD benefits in a classification (inpatient, outpatient, prescription drugs, and emergency care) if the FR or QTL is more restrictive than the predominant financial requirement or treatment limitation of that type that applies to substantially all M/S benefits in the same classification. The cost analysis consists of looking at each type of FR and QTL on MH/SUD benefits in each classification and applying a data-driven mathematical formula (the two-part test) to determine whether that type of FR or QTL applies to substantially all of the M/S benefits in the same classification. If it does, then the level of the FR or QTL is evaluated to determine whether it is equivalent to or less restrictive than the predominant level of that type of FR or QTL for M/S benefits in that classification.

*Tip 5a:* If no FRs or QTLs apply to MH/SUD benefits in a particular benefit package, then the cost analysis does not need to be conducted for that benefit package. Similarly, if there is no FR or QTL on MH/SUD benefits in a particular classification, the cost analysis is not needed for that classification. Also, if one or more FRs or QTLs apply to MH/SUD benefits in a particular classification, but on their face they are no more restrictive than the same FRs or QTLs that apply to M/S benefits in that classification (e.g., 10 percent coinsurance for all inpatient MH/SUD benefits versus 15 percent coinsurance for *all* (i.e., more than two-thirds) inpatient M/S services), the cost analysis is not needed for that classification.

If FRs or QTLs apply to MH/SUD benefits in a classification and a cost analysis is necessary, an analysis must be performed for each FR or QTL on the basis of the projected costs for all M/S benefits in the classification for the benefit package. That includes benefits for those enrolled in an MCO, an ABP, or CHIP. However, separate CHIP programs that provide the full EPSDT benefit and ABPs for those under 21 years that cover EPSDT are deemed compliant with the FR and QTL requirements if certain conditions are met. See Toolkit sections 7 and 8.1.2.1. When projecting the total dollar amount expected to be paid for M/S benefits, include any anticipated changes to the program that may have a material impact on the cost or composition of services during the testing period. Examples of notable changes include, but are not limited to, changes in covered services, changes to covered populations, or material changes in utilization and unit cost reimbursement levels.

The cost analysis is done using a two-part test:

### 5.2.1 Part I: The Substantially All Test (Two-Thirds Test)

To determine whether a type of financial requirement (e.g., copayment or coinsurance) or QTL (e.g., session limit; day limit) may apply to a MH/SUD benefit in a classification for an applicable benefit package, the FR or QTL must pass the *substantially all* test. To pass this test, a type of FR or QTL must apply to at least two-thirds (i.e., substantially all) of the expected payments in a year for all M/S benefits in the same classification.

*Example A:* A state provides comprehensive M/S and MH/SUD services through MCOs. For adults, the MCO limits residential treatment for a SUD (which is mapped to the inpatient classification) to 90 days a year, and the only day limit that exists on inpatient M/S benefits is for inpatient rehabilitation. It is unlikely that the 90-day limit (a QTL) will pass the substantially all test (i.e., at least two-thirds of inpatient M/S benefits must have a day limit) because only a very limited M/S benefit has any day limit. If it does not pass this first part of the test, the QTL cannot be applied to residential treatment for SUDs, regardless of level.

*Example B:* The same facts as example A, except that for adults, most M/S services in the inpatient classification are subject to a day limit (either a 90-day limit or a 120-day limit). Total projected M/S payments in the inpatient classification for the applicable benefit package and time period are \$5,000,000. Of the \$5,000,000, \$4,000,000 is projected for payments with day limits. This passes the substantially all test because at least two-thirds of all inpatient M/S benefits in the applicable classification for that benefit package have a day limit. See Table 5.

### 5.2.2 Part II: The Predominant Test (One-Half Test)

If the type of FR or QTL passes the substantially all test, then the predominant test is required to determine the permissible level of the FR or QTL. To pass the *predominant* test, the level (or magnitude) of the type of FR (e.g., \$5 copayment) or QTL (e.g., 90-day visit limit) applied to an MH or SUD benefit also must apply to more than one-half (i.e., the predominant amount) of the payments for M/S benefits in the classification that are subject to that type of FR or QTL.

*Example C:* Using the same facts as example B, the MCO looks at the projected payments for M/S benefits in the inpatient classification for the benefit package subject to the applicable level of a QTL—in this case a 90-day limit. The MCO determines that of the \$4,000,000 in expected payments for inpatient M/S benefits that are subject to a day limit, only \$750,000 is expected to be paid for payments that involve 90-day limits (the remaining payments involve 120-day limits for inpatient). Because the 90-day limit does not apply to more than one-half of expected inpatient M/S payments that are subject to a day limit, it is not predominant (\$750,000 is only 18.75 percent of \$4,000,000). Therefore, the MCO cannot apply the 90-day limit to residential treatment for SUD. However, the MCO could apply the 120-day limit (or a higher limit) to residential treatment for SUD because that level of the QTL is associated with more than one-half of

the projected payments for inpatient M/S benefits associated with a day limit (the 120-day limit applies to \$3,250,000 [\$4,000,000 minus \$750,000] of expected payments), this is 81.25 percent of the total expected payments for M/S benefits subject to day limits within the inpatient classification (\$4,000,000), which is greater than 50 percent, as required. See Table 5.

**Table 5: Examples B and C—Inpatient Classification**

Medical/Surgical Service	Limit	Historical (M/S) Payments, \$	Projected M/S Payments, \$	Passes the Substantially All Test? (Example B)	Predominant Limit (Example C)
Skilled nursing facility	None	1,000,000	1,000,000	No	NA
Hospice	90-day limit	750,000	750,000	Yes	\$750,000 / \$4,000,000 <sup>b</sup> = 18.75%
Inpatient hospital	120-day limit	2,708,333	3,250,000 <sup>a</sup>	Yes	\$3,250,000 / \$4,000,000 <sup>b</sup> = 81.25%
Inpatient classification total		4,458,333	5,000,000	\$4,000,000 <sup>b</sup> / \$5,000,000 <sup>c</sup> = 80% <sup>d</sup>	120-days = predominant limit <sup>e</sup>

Abbreviations: M/S, medical surgical; NA, not applicable.

<sup>a</sup> Reflects known fee increase on inpatient hospital services of 20 percent.

<sup>b</sup> \$4,000,000 represents the total projected payments for M/S benefits subject to a day-limit (indicated as Yes) in the Inpatient benefit classification. Note that this amount (\$4,000,000) becomes the new universe of costs used in the predominant test.

<sup>c</sup> \$5,000,000 represents the total projected payments for M/S benefits in the inpatient benefit classification.

<sup>d</sup> Passes the substantially all test because at least two-thirds of the total projected payments for M/S benefits in the classification are subject to that type of limitation (i.e., day limit).

<sup>e</sup> The predominant limit is 120-days because at least one-half of the projected payments for M/S benefits with that type of quantitative treatment limitation (a day limit) are subject to a 120-day limit. In the instance that a single day limit does not apply to more than one-half of the projected payments subject to a day limit, benefits may be combined until the projected payments for benefits subject to a day limit total more than one-half of all projected payments in that classification. The least restrictive day limit applied to this group of benefits then is considered the predominant limit and can be applied to mental health and substance use disorder benefits in that classification.

*Tip 5b:* A state/MCO (as applicable) will not always have to perform the analysis using projected cost data if it is possible to determine the two-part test without it. For instance, example A above describes a scenario in which the only day limit for inpatient M/S benefits is for inpatient rehabilitation. Because such costs are unlikely to cover two-thirds of all inpatient M/S benefits, a state/MCO could conclude without doing an analysis that the design does not pass the

substantially all test. If the state/MCO determines that it will eliminate all day limits on SUD benefits and rely on medical management techniques for assessing the appropriate time of discharge for SUD, any medical management processes used would need to be evaluated under separate rules for NQTLs. See Toolkit section 6.

*Example D:* State K has a separate CHIP program that has a benefit package with a \$200 inpatient per admission copayment for both M/S and MH/SUD services. The state wants to determine whether it can keep this \$200 copayment on all MH/SUD inpatient services under the parity law. All M/S services in the inpatient classification have the same \$200 copayment. As a result, all projected payments for M/S benefits in this classification involve a copayment (i.e., passes the substantially all test) and the \$200 level applies to 100 percent of the benefits associated with a copay (passing the predominant test). Applying the \$200 per admission copayment to inpatient MH/SUD benefits complies with parity.

### *5.2.3 Can Subclassifications Be Used?*

The cost analysis must be performed within each of the four classifications. Generally, the classifications cannot be subdivided. However, there are two exceptions that allow subclassifications of M/S and MH/SUD benefits:

**Outpatient subclassification.** For purposes of applying the requirements regarding FRs and QTLs, the outpatient classification may be divided into (1) office visits (e.g., physician visits) and (2) all other outpatient items and services (e.g., outpatient surgery, laboratory charges, or facility charges for intensive outpatient services). No other subdivisions are allowed in this classification. (E.g., primary care office visits cannot be separated from specialist office visits.) Using this subclassification is optional, and it can be used for some benefit packages and not others. Although it is optional, once a decision is made to use these subclassifications for a benefit package, all outpatient benefits must be mapped specifically to either (1) office visits or (2) all other outpatient items and services. Once the subclassifications are used, no FR or QTL may be applied to MH/SUD benefits in a subclassification that is more restrictive than the predominant FR or QTL that applies to substantially all M/S benefits in the subclassification.

*Example E:* A state has a \$2 copayment for primary care office visits and a \$4 copayment for specialist visits (including MH/SUD specialist office visits) for adults with income over 100 percent of the Federal Poverty Level (FPL). It also has 10 percent coinsurance for all other outpatient benefits for adults with income over 100 percent of the FPL. The state needs to determine whether it can keep the \$4 copayment for the MH/SUD specialist office visit under the parity rules. Total projected payments for M/S benefits in the outpatient classification equal \$10,000,000, but only \$5,000,000 of the projected payments involve copayments (the other \$5,000,000 involves outpatient payments with 10 percent coinsurance). The FR that is a copayment would not pass the substantially all test for the outpatient classification as a whole, because the \$5,000,000 for projected

payments for M/S benefits subject to copayments does not reach the required two-thirds of the total projected payments for M/S benefits in that outpatient classification (it is only 50 percent of the \$10,000,000 total). See Table 6.

As an alternative, the state can subdivide the outpatient classification into office visits and all other outpatient items and services. The cost analysis is done separately for office visits and all other outpatient items and services. Of the \$5,000,000 total for M/S office visits, all \$5,000,000 is associated with a copayment, so the copayment passes the substantially all test. The \$4,000,000 in projected payments involves the \$2 copayment for primary care office visits, whereas \$1,000,000 involves the \$4 specialist copayment. As a result, the \$4 specialist copayment applies to only 20 percent of the outpatient office visit projected payments for M/S benefits that are subject to a copayment, so it does not pass the predominant test and the state cannot keep the \$4 copayment for the MH/SUD specialist office visit. It can apply the \$2 copayment to MH/SUD office visits because the \$2 copayment applies to more than 50 percent (i.e., 80 percent) of projected payments associated with M/S outpatient office visits that are subject to a copayment. Alternatively, the state may choose to eliminate the copayment. See Table 7.

**Table 6. Example E—Two-Part Test *Without* Outpatient Subclassification**

Classification	Substantially All Test	Predominant Test	Outcome
Outpatient	Total Projected M/S payment = \$10,000,000 Total Projected M/S payments subject to copayments = \$5,000,000 % of services subject to a copayment = 50% (does not pass two-thirds test)	Not applicable	Benefit package cannot have any copayment for outpatient MH/SUD

Abbreviations: MH, mental health; M/S, medical/surgical; SUD, substance use disorder.

**Table 7. Example E: Two-Part Test *With* Outpatient Subclassification**

Classification		Substantially All Test	Predominant	Outcome
Outpatient	A. Office visit	Total projected M/S payments for all office visits = \$5,000,000  % of office visit payments that are subject to copayments = 100% (passes two-thirds test)	Total projected M/S payments that are subject to a copayment, that are subject to \$2 copayment = \$4,000,000 (80% of the \$5,000,000 subject to copayment—more than one-half, passes predominant test)  Total projected M/S payments that are subject to a copayment, that are subject to \$4 specialist copayment = \$1,000,000 (20% of the \$5,000,000 subject to copayment total—not more than one-half, does not pass predominant test)	Benefit package can have an office visit copayment for MH/SUD up to \$2  Benefit package cannot have a \$4 office visit copayment for MH/SUD
	B. Other	Total projected M/S payments for other outpatient services = \$5,000,000  Total projected M/S payments for other outpatient services subject to coinsurance = 100% (passes two-thirds test)	Total projected M/S payments for “other outpatient” that are subject to coinsurance, that are subject to 10% coinsurance = \$5,000,000 (100% of the \$5,000,000 subject to coinsurance—more than one-half, passes predominant test)	Benefit package can include 10% coinsurance for “other outpatient” MH/SUD

Abbreviations: MH, mental health; M/S, medical/surgical; SUD, substance use disorder.

**Prescription drug tiers.** A state, MCO, PIHP, or PAHP may apply different levels of FRs to different tiers of prescription drugs if the tiers are based on reasonable factors (such as costs, efficacy, generic versus brand name, or mail order versus pharmacy pick-up/delivery) determined according to requirements for NQTLs (see Toolkit section 6.2) and without regard to whether a drug is generally prescribed for MH/SUD or M/S conditions. For example:

Drug Cost, \$	Copayment, \$
10.00 or less	0.50
10.01 to 25.00	1.00
25.01 to 50.00	2.00
50.01 or more	3.00



The FRs associated with each tier above are permissible under parity because the tiers were established on the basis of reasonable factors (i.e., costs) without regard to whether a drug is generally prescribed for MH/SUD or M/S conditions.

#### *5.2.4 Are Cumulative FRs or QTLs Allowed?*

The Medicaid and CHIP parity regulations define *cumulative financial requirements* as FRs “that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums.” This type of financial requirement is allowed under the parity rules, but the state, MCO, PIHP, or PAHP cannot apply separate cumulative financial requirements to M/S and MH/SUD benefits in a classification (e.g., a deductible for M/S outpatient benefits and a separate deductible for MH/SUD outpatient benefits).

Although deductibles are rare in Medicaid and CHIP programs, cumulative quantitative treatment limitations, such as separate annual or lifetime day or visit limits for M/S and MH/SUD benefits, could be used. Unlike the commercial parity rules, the Medicaid parity rules allow these cumulative quantitative treatment limitations to apply separately for M/S and MH/SUD benefits. However, the two-part test discussed above must be applied to separate cumulative quantitative treatment limitations to determine whether a cumulative quantitative treatment limitation for MH/SUD benefits is no more restrictive than the predominant limit applied to substantially all M/S benefits in the relevant classification.

*Tip 5c:* Do not assume that a cumulative QTL that is exactly the same for MH/SUD and M/S benefits in a classification will comply with parity. For instance, if a benefit package has a 20-visit limit on personal care for treatment of an MH/SUD condition and a separate 20-visit limit for personal care for a M/S benefit, it may not necessarily pass the two-part test. The two-part test looks to M/S projected claim dollars within the relevant classification to determine parity compliance. If projected claim amounts for all M/S benefits associated with visit limits in the outpatient classification do not amount to at least two-thirds of all projected M/S payments in the outpatient classification, the visit limit will not pass the substantially all part of the two-part test. The state will not be able to apply the 20-visit limit to MH/SUD personal care benefits even if it is retained for M/S personal care.

#### *5.2.5 Using and Documenting a “Reasonable” Method to Determine the Dollar Amount of Payments*

The mathematical calculations in the cost analysis for FRs and QTLs require a determination of the dollar amount of all payments for M/S benefits in the classification expected to be paid during a specific year. The final rules say that “any reasonable method” may be used to determine the dollar amount expected to be paid for M/S benefits in a classification, with some exceptions.

Few parameters have been set on the reasonable methods that can be used to determine these dollar amounts, but the following applies:



- Data specific to the benefit package being evaluated must be used to make projections for the dollar amounts expected to be paid during the relevant period, if such data are available and sufficient.<sup>6</sup> If data are not available or sufficient for the specific benefit package, then data can be combined from other, similarly structured benefit packages for similar populations, if the data are adjusted to be comparable to the benefits and population being assessed to conduct the analysis. An MCO should not use its entire book of business to do this projection, because the book of business often includes many plans that may have benefit designs that bear little resemblance to the specific benefit package for which the parity analysis is being conducted.
- Total dollar amounts consist of all combinations of MCO, PIHP, PAHP and FFS payments for M/S benefits in a classification expected to be paid in a contract year. For instance, if a benefit package includes M/S benefits that are provided by an MCO, a PIHP, or a PAHP, total M/S payments from all entities providing M/S benefits must be used to project the total M/S dollar amounts in each classification.
- For deductibles, the dollar amount of MCO, PIHP, or PAHP payments must include all payments for claims that would be subject to the deductible regardless of whether it had been satisfied. Similarly, for out-of-pocket maximums, the dollar amounts include all payments associated with out-of-pocket payments that are counted toward the out-of-pocket maximum, as well as payments associated with out-of-pocket payments that would have been made toward the out-of-pocket maximum had it not been satisfied.
- For MCOs, PIHPs, and PAHPs the dollar amount projected is for payment *during a contract year*, or for the portion of a contract year after a change in benefits that affects the applicability of the financial requirement or quantitative treatment limitation.
- For ABP and CHIP state plans, the dollar amount is the projected amount for the year starting with the effective date of the Medicaid/CHIP rule (10/2/17).

States will need to demonstrate, and should ask MCOs to demonstrate, not only the results of the cost analysis, but also the methodology used to conduct the testing (including how services were defined and mapped), the data sources used, and the percentages determined for each FR and QTL for M/S benefits within each classification in each benefit package. In addition, the information should indicate whether the outpatient office visit subclassification was used and explain the reasonable factors and NQTL analysis used to develop separate prescription drug tiers. A template spreadsheet could be used to track this information. If a state uses a third party to conduct the cost analysis, or must obtain information from an MCO, PIHP or PAHP, the

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<sup>6</sup> For information about what an MCO/state should do if it does not have sufficient claims data to do the cost analysis, see Question #3 in FAQs About Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation, dated October 27, 2016. The FAQs can be found on the Department of Labor's website.

template spreadsheet can be used to share information. See section 5.4 for an example of one template that could be used for this purpose. Any state conducting the parity analysis will want to provide this information to demonstrate compliance to CMS as part of their contract review. The information may also be needed as part of the documentation of compliance for the general public. MCOs doing the parity analysis also will use this information to demonstrate compliance to the general public.

*Tip 5d:* When an FR or QTL is changed to comply with parity, the cost analysis of the new FR or QTL also may be useful for assessments of the budget implications and capitation rate impact of the change.

*Tip 5e:* States should identify a standard for determining when a new cost analysis is needed. The final rule indicates that an updated analysis must be done when there are changes in operation or benefit design; CMS guidance in the preamble to the final rule suggested that updated analyses could be done only when changes could affect compliance. To comply with this requirement, all parties involved in the analysis should know the circumstances in which an update is needed—whether that is for every change to a benefit package, a change to the population covered, changes in utilization review, annually, or at another frequency. States should consider requiring MCOs to update their analysis using the standard that the state sets and to provide the information in the template to the state by a specific date.

### 5.3 Cost Analysis for Aggregate Lifetime and Annual Dollar Limits

A different cost analysis applies to AL/ADLs. An aggregate lifetime dollar limit is a dollar limit on the total amount of specified benefits that may be paid (e.g., gender transformation surgeries up to a maximum of \$25,000 lifetime). An annual dollar limit is a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period (e.g., coverage for inpatient treatment for a substance use disorder up to \$50,000 per year).

- If the aggregate lifetime or annual dollar limit applies to *less than one-third* of expected payments for all M/S benefits in a year, an AL/ADL may not be imposed on MH/SUD benefits.

*Example F:* State Y has a separate CHIP program with a \$50,000 annual dollar limit on inpatient treatment for a SUD. There are no annual dollar limits on any M/S services in the CHIP program. Under the final parity rules, state Y must remove the annual dollar limit on inpatient treatment for a SUD if it continues to have no annual dollar limits or only applies annual dollar limits on less than one-third of projected costs for all M/S benefits in the CHIP program.

- If an AL/ADL applies to *at least two-thirds* of all expected payments for M/S benefits in a year, either—

- Apply the AL/ADL to *both* the M/S and MH/SUD benefits subject to the limit without distinguishing between the M/S benefits and MH/SUD benefits or
- Apply an AL/ADL on MH/SUD benefits that is no more restrictive than the AL/ADL on M/S benefits.

If an AL/ADL applies to between one-third and two-thirds of expected payments for M/S benefits in a year, an AL/ADL may be applied to MH/SUD benefits if it is no more restrictive than the weighted average of the limit applied to the M/S benefit, calculated in accordance with the regulation.

Similar to the cost analysis for FRs and QTLs, any reasonable method can be used to determine the expected dollar amounts to be paid. The methodology, data sources, and specific percentages should be documented.

*Tip 5f:* Medicaid requirements regarding sufficiency, access, and comparability still apply. Thus, any AL/ADLs allowed under the Medicaid parity rules still must meet Medicaid standards for sufficiency, access, and comparability.

#### 5.4 Example Template for Two-Part Test

Any template that the state uses should be completed for each benefit package that contains any FR or QTL applied to an MH/SUD benefit in a classification. This template is designed to show the results of the two-part test for all FRs and QTLs where testing is necessary. States could create additional charts or templates to collect more specific information about how the testing was conducted.

Name of benefit package: \_\_\_\_\_

Time period being evaluated: \_\_\_\_\_

#### Financial Requirements

List FRs on MH/SUD:

- \$10 copayment for all outpatient MH/SUD benefits

Classification <sup>a</sup>	Medical/Surgical Projected Payments, \$ <sup>b</sup>	Subject to Deductible			Subject to Copay			Subject to Coinsurance			Subject to Out of Pocket Maximum		
		\$	Substantially All Test, %	Predominant Limit, \$	\$	Substantially All Test, %	Predominant Limit, \$	\$	Substantially All Test, %	Predominant Limit, \$	\$	Substantially All Test, %	Predominant Limit, \$
Inpatient	5,000,000	0	0.0	NA	0	0.0	NA	0	0.0	NA	5 mill	100.0	5,000
Outpatient <sup>c</sup>	18,000,000	0	0.0	NA	18 mill	100.0	\$10	0	0.0	NA	18 mill	100.0	5,000
Emergency care	5,000,000	0	0.0	NA	0	0.0	NA	0	0.0	NA	5 mill	100.0	5,000
Prescription drugs <sup>d</sup>	10,000,000	0	0.0	NA	0	0.0	NA	0	0.0	NA	10 mill	100.0	5,000

Abbreviation: NA, not applicable.

<sup>a</sup> States also could collect in a separate appendix a list of all medical/surgical services and projected costs included in the testing within each classification.

<sup>b</sup> States also could collect in a separate appendix a description of the methodology used for the two-part test.

<sup>c</sup> If the office visit subclassification was used, a separate appendix could be added to list and explain why services were included in the office visit subclassification versus “other outpatient” classification.

<sup>d</sup> If different financial requirements apply to different tiers of prescription drugs, a state could in a separate appendix request information on the tiers with an explanation of the basis for tier development.

#### Quantitative Treatment Limitations

List QTLs on MH/SUD benefits :

- 120-day limit on inpatient substance use disorder treatment

Classification <sup>a</sup>	Medical/Surgical Projected Payments, \$ <sup>b</sup>	Subject to Annual Day Limitation			Subject to Episode Limitation			Subject to Lifetime Day Limitation		
		\$	Substantially All Test, %	Predominant Limit, Days	\$	Substantially All Test, %	Predominant Limit, Episodes	\$	Substantially All Test, %	Predominant Limit, Days
Inpatient	5,000,000	4,000,000	80.0	120	0	0.0	NA	0	0.0	NA
Outpatient <sup>c</sup>	18,000,000	0	0.0	NA	0	0.0	NA	0	0.0	NA
Emergency care	5,000,000	0	0.0	NA	0	0.0	NA	0	0.0	NA
Prescription drugs	10,000,000	0	0.0	NA	0	0.0	NA	0	0.0	NA

Abbreviation: NA, not applicable.

<sup>a</sup> States also could collect in a separate appendix a list of all medical/surgical services and projected costs included in the testing within each classification.

<sup>b</sup> States also could collect in a separate appendix a description of the methodology used for the two-part test.

<sup>c</sup> If the office visit subclassification was used, a separate appendix could be added that lists and explains why services were included in the office visit subclassification vs. “other outpatient” classification).

## 6. Identifying and Analyzing Non-Quantitative Treatment Limitations (NQTLs)

### 6.1 What is an NQTL?

A non-quantitative treatment limitation (NQTL) is a limit on the scope or duration of benefits, such as prior authorization or network admission standards. *Soft limits*, or benefit limits that allow for an individual to exceed numerical limits for M/S or MH/SUD benefits on the basis of medical necessity, also are considered NQTLs. The final Medicaid/CHIP parity regulations include an illustrative list of NQTLs sufficient to provide an understanding of the nature of an NQTL, but the list is not exhaustive. The list includes the following:

- Medical management standards limiting or excluding benefits on the basis of medical necessity or medical appropriateness, or on the basis of whether the treatment is experimental
- Formulary design for prescription drugs
- Standards for provider admission to participate in a network, including reimbursement rates
- Refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective
- Conditioning benefits on completion of a course of treatment
- Restrictions based on geographic location, facility type, or provider specialty
- Standards for providing access to out-of-network providers

### 6.2 What are the Parity Requirements for NQTLs?

Parity prohibits states, MCOs, PIHPs, or PAHPs (as applicable) from imposing an NQTL on MH/SUD benefits (see section 3 of this Toolkit for information on defining MH/SUD benefits) in any classification (see section 4 of this Toolkit for information on defining classifications and mapping benefits to classifications) unless, under the policies and procedures of the state, MCO, PIHP, or PAHP, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification.

As a result, the NQTL analysis can be divided into two parts:

1. Evaluate the *comparability* of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying the NQTL to MH/SUD benefits and M/S benefits
2. Evaluate the *stringency* with which the processes, strategies, evidentiary standards and other factors (in writing and operation) are applied to MH/SUD benefits and M/S benefits

### 6.3 Examples Illustrating Each Part of the NQTL Analysis

*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 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.

When the two-part NQTL analysis is conducted, it is not required that the result of applying an NQTL to MH/SUD and M/S benefits be the same for MH/SUD and M/S benefits for the NQTL to be permissible. Instead, compliance depends on parity of the processes, strategies, evidentiary standards, and other factors used to apply the NQTL (in writing and in operation). Among other things, there should not be arbitrary or discriminatory differences in how a state or MCO/PIHP/PAHP applies NQTLs to M/S benefits as compared with MH/SUD benefits.

*Example:* MCO X conducts utilization review (which is an NQTL) every 3 days for inpatient M/S services with lengths of stay that are highly variable (as measured by a coefficient of variation exceeding 0.8). MCO X also conducts utilization review every 3 days for inpatient MH/SUD services with lengths of stay that are highly variable (as measured by a coefficient of variation exceeding 0.8). During these reviews, the medical necessity of services is evaluated and coverage for some services may be denied. The criterion used to determine the circumstances under which the NQTL is applied (i.e., coefficient of variation exceeding 0.8) is comparable, and no more stringently applied, to MH/SUD inpatient services than it is to M/S inpatient services. This NQTL is likely permissible under parity even if the result of applying this NQTL is that only 30 percent of M/S inpatient services are reviewed and 60 percent of MH/SUD services are reviewed.

#### 6.4 An NQTL Analysis Is Conducted Across Services Within a Classification, Not on a Service-to-Service Basis

The NQTL analysis is conducted for each type of NQTL that applies to MH/SUD benefits *in a classification*; not on a service-to-service basis. Parity does not require coverage of a similar M/S service in a classification for states to cover a MH/SUD service or to apply NQTLs to a unique MH/SUD service. Instead, each type of NQTL is tested only once in a classification, regardless of the type or number of services it limits. It is important, however, to identify and evaluate any differences in the processes, strategies, evidentiary standards, or other factors used in applying the type of NQTL to each service as part of the analysis.

*Example:* Assertive Community Treatment (ACT) is an intensive mental health service, often delivered outside of an office or hospital setting, designed to promote a consumer's independence, rehabilitation, and recovery, while preventing unnecessary hospitalization. State X has assigned ACT to the outpatient classification. No similar outpatient M/S benefit is covered. But this does not preclude state X from covering ACT, nor does it prevent state X from applying an NQTL to ACT if that NQTL is consistent with parity standards.

State X assigned a prior authorization requirement to ACT because the services are costly and certain patient qualifying criteria must be met for safe and effective implementation as required by applicable national practice guidelines. Similarly, state X assigned prior authorization requirements to several outpatient surgeries because they are costly and require specific patient qualifying criteria to be met for safe and effective implementation.

MCO J administers state X's M/S Medicaid benefits and PIHP K administers state X's MH/SUD benefits. MCO J's written policy and procedures require telephonic prior authorization for the specified outpatient surgeries. During the prior authorization process, a nurse confirms eligibility and evaluates medical necessity and appropriateness of the proposed service. If a nurse is unable to authorize the surgery, a physician conducts the medical necessity review. Failure to obtain prior authorization results in no coverage.

PIHP K's written policy and procedures also require telephonic prior authorization for ACT services to evaluate medical necessity. During the prior authorization process, a trained customer service representative (CSR) confirms eligibility and authorizes ACT. Weekly supervision and semiannual interrater reliability testing is conducted to evaluate CSR authorization decisions. If the CSR is unable to authorize ACT, a psychiatrist conducts the medical necessity and appropriateness review. Failure to obtain prior authorization results in no coverage.

The prior authorization requirements for ACT are likely permissible under the parity standards of the final rule because the processes, strategies, evidentiary standards, and



other factors are comparable and applied no more stringently to ACT than they are to the outpatient surgeries. Although the qualifications for the person who conducts the initial screening for ACT are different from those for the outpatient surgeries, they are still comparable (e.g., criteria application training, supervision, and interrater reliability testing are comparable to nurse qualifications to make authorization decisions), and the difference in processes does not result in a more stringent application of the NQTL (i.e., for both M/S and MH/SUD benefits, the decision *not* to authorize is reviewed by a physician).

### 6.5 How Is the NQTL Analysis Conducted?

The first step in conducting an NQTL analysis is to identify all of the NQTLs applicable to MH/SUD benefits in each classification. A type of NQTL must be tested in each classification in which it applies. Because the parity rule does not provide an exhaustive list of NQTLs, the state, MCO, PIHP, or PAHP, as applicable, must identify any limits on the scope or duration of a MH/SUD benefit. Some NQTLs (e.g., prior authorization requirements) are readily identifiable in the state plan, manuals, or other documentation, but other NQTLs require more in-depth analysis about the state's, MCO's, PIHP's, or PAHP's written policies and procedures and their operations related to utilization and quality management, provider network admission standards, reimbursement rates, prescription drug tiering factors, medication dispensing requirements, and other NQTLs embedded in administrators' operations. The state may require the assistance of MCOs, PIHPs, PAHPs, its Medicaid Management Information Systems contractor, pharmacy benefit managers, or utilization management contractors with identifying NQTLs.

Once NQTLs are identified for a benefit package, the state or MCO must collect information about the processes, strategies, evidentiary standards, and other factors applicable to each type of NQTL relative to M/S and MH/SUD benefits in each classification, including information regarding whether and to what extent a benefit is subject to an NQTL. The state/MCO then conducts the NQTL analysis on the basis of that information to determine compliance with parity requirements.

*Example:* State Y develops an NQTL questionnaire in which it asks MCOs about their written policies and procedures and operations related to the selection and development of medical necessity and appropriateness criteria for M/S and MH/SUD benefits. MCO G replies that for M/S benefits in all classifications, evidentiary standards are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for an M/S condition. Similarly, MCO G indicates that evidentiary standards used in determining whether an MH/SUD treatment is appropriate are based on recommendations made by panels of experts with training and experience in the fields of MH/SUD involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for an MH/SUD

condition. Further, MCO G requires its MH/SUD subcontractor to annually update the criteria with input from providers who deliver related services. The NQTL passes the NQTL test because the processes for developing the evidentiary standards used to determine medical necessity, and the application of these standards for determining which MH/SUD benefits will be covered, are comparable to those for M/S benefits and no more stringently applied to MH/SUD benefits in writing and in operation.

When a benefit includes multiple service components, and each service component is subject to a different type of NQTL, the NQTLs must be analyzed separately.

*Example:* PAHP X covers MAT for opioid disorders, components of which are mapped to the outpatient and prescription drug classifications. A review of PAHP X's written and operating policies and procedures resulted in the identification of two types of NQTLs: network admission standards and prior authorization in the outpatient classification.

1. The network admission standards for MAT providers include requirements for prescribing clinicians to be certified or to obtain a waiver before they can prescribe buprenorphine and federal certification for opioid treatment programs that dispense methadone. PAHP X applies these requirements consistent with the Controlled Substances Act and federal regulations and does not embellish them. Similarly, MCO B requires Drug Enforcement Administration registration for prescribers of Schedule II narcotics for treatment of pain consistent with the Controlled Substances Act and federal regulations. Because both PAHP X and MCO B are applying these network admission standards consistent with federal law and PAHP X applies them no more stringently to MH/SUD providers than what is required by law, these NQTLs are permissible under parity.
2. In addition to the network admission requirements, state A requires prior authorization (PA) for methadone dosages over a predetermined level for adults due to an increased risk of death or abuse. This PA requirement applies regardless of whether methadone is used for the treatment of opioid disorders or for pain management. In addition, other medications for treatment of M/S conditions require PA when there is an increased risk of death or abuse. Food and Drug Administration recommendations and medication-specific, nationally recognized clinical practice guidelines are used to confirm the degree of risk, abuse potential, and dosage threshold for each medication assigned a PA requirement. PA procedures are the same, regardless of the condition treated.

The prior authorization requirement for methadone dosages over a predetermined level for adults passes the comparability and stringency portions of the NQTL analysis because the processes, strategies, and evidentiary standards are comparable and no more stringently applied to methadone when it is used as a

treatment for opioid disorders than when it is used for pain management or to other medications for M/S conditions.

## 6.6 Tips for Identifying NQTLs

The NQTL analysis cannot be performed by simply scanning a list of M/S and MH/SUD benefits for differences. Many NQTLs exist within state, MCO, PIHP, and PAHP policies, procedures, and operations.

*Example:* State E covers personal care services for MH. For coverage of personal care services for MH conditions to continue, the PAHP requires concurrent review every 6 months. Because the concurrent review requirement is embedded in the PAHP's policies and not evident in the list of covered benefits, this NQTL would not be identified unless an inventory of the PAHP's medical necessity and appropriateness practices and utilization review approaches is conducted.

Below are some tips for identifying and analyzing NQTLs.

*Tip 6a:* Review a list of all covered MH/SUD benefits in each classification. Check for NQTLs such as prior authorization requirements, penalties for noncompliance, coding limitations, conditions on coverage, or any other factors that potentially limit the scope or duration of MH/SUD benefits. A permanent exclusion of all benefits for a particular MH/SUD condition is not a treatment limitation under parity requirements (but condition exclusions may not be permissible under other applicable law).

*Tip 6b:* To analyze the NQTLs identified in Tip 6a, develop a tool to collect the information necessary to conduct a full NQTL analysis. In addition, add questions to identify and analyze NQTLs that may be embedded in state, MCO, PIHP, or PAHP operations, policies, and procedures. Use the examples provided in the final Medicaid and CHIP parity rule and the information provided in the Department of Labor's Self-Compliance tool for Part 7 of the Health Care-Related Provisions of the Employee Retirement Income Security Act of 1974, pages 85–87, as guides for what questions to ask.

*Tip 6c:* Conduct a new NQTL analysis for any of the following circumstances:

- Applying a new limit to MH/SUD benefits, operations, policies, or procedures
- Changing or removing precertification requirements from inpatient or outpatient M/S benefits
- Contracting with new vendors/plans for management of all or part of the state's M/S or MH/SUD benefits (consider evaluating parity compliance as part of any request for proposal)

*Tip 6d:* Contractually require vendors and MCOs, PIHPs, and PAHPs to cooperate with all parity analyses *and* to participate in resolution of impermissible NQTLs, which may include changes to the benefit administrators’ operations, policies, or procedures.

## 6.7 Collecting Information to Conduct an NQTL Analysis

As described above, states/MCOs must collect information about the processes, strategies, evidentiary standards, and other factors, in writing and in operation, used in applying an NQTL to benefits. This information is collected by benefit package and includes the following:

- The type of NQTL (e.g., prior authorization, reimbursement rates)
- The MH/SUD service or services to which the NQTL applies in a classification
- Policies and procedures, both written and in operation, associated with the development of the NQTL and its application to MH/SUD benefits in a classification. (If the NQTL is applied to MH/SUD benefits in more than one classification, this information will need to be collected for each classification in which the NQTL is applied to MH/SUD benefits.)
- The M/S service or services to which the NQTLs identified above apply in the same classification
- Policies and procedures, both written and in operation, associated with the application of these NQTLs to M/S benefits in the same classification

There is no required format or methodology for collecting the information necessary for an NQTL analysis. Below are two examples of tools that could be used for NQTL data collection.

### 6.7.1 NQTL Tool Development—Example A

In example A, the state or MCO structures an NQTL questionnaire using the examples of NQTLs provided in the final rule. In this approach, the NQTL questionnaire asks the responder to identify the NQTLs applicable to MH/SUD and M/S benefits in each classification for each benefit package. Example NQTLs from the final rule are used as prompts. These NQTLs include medical management standards limiting or excluding benefits on the basis of the following factors:

- Medical necessity, appropriateness, or whether the treatment is experimental or investigational
- Standards for provider admission to participate in a network, including reimbursement rates
- Refusal to pay for higher-cost therapies until a lower-cost therapy has been proven ineffective
- Conditioning benefits on completion of a course of treatment
- Restrictions based on geographic location, facility type, or provider specialty
- Standards for providing access to out-of-network providers

The questionnaire then provides a structure in which the responder can describe the NQTL and applicable processes, strategies, evidentiary standards and other factors for each NQTL.

Each entity administering benefits for a specific benefit package completes this questionnaire separately. The state will compile the information collected from each entity into a side-by-side chart analysis for each combination of entities delivering the benefit package. (Alternatively, if the MCO is conducting the analysis, the MCO will compile information collected about the NQTL as it applies to MH/SUD and M/S into a side-by-side chart for analysis.) For instance, if XYZ Medicaid Benefit Package consists of M/S and MH/SUD benefits provided to a group of Medicaid beneficiaries by a combination of an MCO, a PIHP, and a PAHP, the state could compile information from the questionnaires for all NQTLs for M/S and MH/SUD benefits provided by each of the three entities—the MCO, PIHP, and PAHP. The state also may need to complete the questionnaire if it is administering certain benefits as part of the benefit package or making determinations regarding which benefits would be subject to NQTLs.

#### 6.7.1.1 Considerations

This tool requires moderate preparation in advance of template development. Although a state can send this questionnaire concurrently to MCOs, PIHPs, and PAHPs providing M/S and MH/SUD benefits, taking this approach likely will result in collecting more information about M/S NQTLs than is necessary (i.e., states will collect information about M/S NQTLs that are not applied to MH/SUD benefits). In addition, NQTL information for M/S and MH/SUD benefits may only match at the example (e.g., medical management) level rather than for the type of NQTL (e.g., prior authorization or concurrent review) and require additional comparison work by the state and additional follow-up with the MCOs.

This methodology relies on the administering entities for identification and description of specific NQTLs, providing a fair to moderate opportunity for identifying all NQTLs. It permits MCOs, PIHPs and PAHPs to develop a “standard” response for the NQTLs included in the rule and may reduce the entity’s administrative burden for completing the questionnaire. States, however, will need to compare the NQTLs identified in the questionnaire with those included in the state plan and other plan documents to confirm that all NQTLs are addressed in the analysis, increasing the state’s administrative burden. Follow-up data collection may be required regarding state-identified NQTLs that were not identified by the administering entities.

An example of this type of NQTL questionnaire is provided below. This example is not intended to represent a complete NQTL questionnaire.

#### 6.7.1.2 Example NQTL Questionnaire A

##### **NON-QUANTITATIVE TREATMENT LIMITATION (NQTL) QUESTIONNAIRE EXAMPLE A**

Describe the specific NQTLs applicable to MH/SUD benefits for each type of NQTL listed in the questionnaire below. Identify the MH/SUD and M/S benefits to which the NQTL applies in each classification.

After all NQTLs have been listed for a benefit package, complete the second grid for **each** type of NQTL in a classification by describing the processes, strategies, evidentiary standards, and other factors used in applying the NQTL (in writing and in operation) with sufficient detail such that the state/MCO can assess the comparability and stringency with which the NQTL is applied to MH/SUD and/or M/S benefits.

**Entity Name:**

**Entity Type: MCO, PIHP, PAHP, FFS, Other:**

**Benefit Packages Administered:**

Standard Type	NQTL Description	IP	OP	Prescription Drugs	Emergency Care
Medical management standards					
• Medical necessity criteria development					
• Prior authorization					
• Concurrent review					
• Retrospective review					
• Outlier management					
• Experimental/investigational determinations					
• Fail first requirements					
• Exclusions (e.g., based on a failure to complete treatment)					
• Medical appropriateness reviews					
• Practice guideline selection/criteria					
• Requirements for lower cost therapies to be tried first					
Network admission standards					
• Reimbursement rates					
• Geographic restrictions					
• Specialty requirements or exclusions					
• Facility type requirements or additional requirements for certain facility types					
• Network tiers					
Out-of-network access standards					
Methods for determining usual, customary, and reasonable charges					
Formulary design for prescription drugs					
Prescription drug benefit tiers					
Generic vs. brand name					
High cost vs. low cost					

Standard Type	NQTL Description	IP	OP	Prescription Drugs	Emergency Care
Other NQTLs					

Abbreviations: IP, inpatient; OP, outpatient; NQTL, non-quantitative treatment limitation.

Complete the following grid for each NQTL.

NQTL	Describe applicable processes, strategies, evidentiary standards, and other factors	Additional documentation attached (e.g., policies and procedures, reports, data)
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Abbreviation: NQTL, non-quantitative treatment limitations.

### 6.7.2 NQTL Tool Development—Example B

The second example is an individualized, prepopulated NQTL template approach. Each NQTL questionnaire is specific to a benefit package. It requires the state or MCO to structure an NQTL questionnaire on the basis of NQTLs preidentified from a review of plan documents. The state also may be able to complete certain portions of the questionnaire that address why the NQTL was assigned to a benefit or whether the state is administering some portion of the benefits. To capture NQTLs not described in the plan documents, the state also must add questions about the types of NQTLs included in the illustrative examples of NQTLs from the final rule consistent with the structure in Example A.

Like the example above, this questionnaire is completed by each entity administering benefits for a benefit package. For every combination of delivery systems that provide items and services to MCO enrollees, the state will compile the information collected from each entity into a side-by-side chart for analysis. (Alternatively, if the MCO is conducting the analysis, the MCO will compile information collected about the NQTL as it applies to MH/SUD and M/S into a side-by-side chart for analysis.)

#### 6.7.2.1 Considerations

This tool requires significant preparation in advance of template distribution; however, it also avoids the collection of information about M/S NQTLs that are not applicable to MH/SUD benefits. In addition, the questionnaire can be structured to more readily permit side-by-side comparison of specific NQTL information for M/S and MH/SUD benefits, which facilitates the NQTL analysis.

This methodology requires the preidentification of most NQTLs applicable to MH/SUD benefits, potentially improving the NQTL detection rate. Although this approach will likely preclude administering entities from developing standard responses to some NQTL questions, the number of follow-up questions regarding preidentified NQTLs likely will be fewer with this approach.

An example of this type of individualized NQTL questionnaire is provided below. This example is not intended to represent a complete NQTL questionnaire.

*6.7.2.2 Example NQTL Questionnaire B*

**NON-QUANTITATIVE TREATMENT LIMITATION (NQTL) QUESTIONNAIRE EXAMPLE B**

**Entity Name:**

**Entity Type (MCO, PIHP, PAHP, FFS, Other):**

**Benefit Package(s) Administered:**

Complete the NQTL questionnaire for the benefit package(s) listed above. Describe the processes, strategies, evidentiary standards, or other factors as they apply to M/S benefits, in writing and in operation, in column two. In column three describe the processes, strategies, evidentiary standards, or other factors as they apply to MH/SUD benefits in writing and in operation. If another entity is responsible for any part of the processes, strategies, evidentiary standards, or other factors addressed in a specific item, describe your organization's role (if any) as it relates to the item in the appropriate column (two or three). Then identify the other entity, the functions provided by that entity, and the circumstances under which the other entity is responsible for that item. If the state has prepopulated some of the boxes in the grid, please confirm the accuracy of that information or describe how the information should be modified. In column four, identify any attachments that are provided to further describe the NQTL processes, strategies, evidentiary standards, or other factors.



Item	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
<b>Medical Necessity and Appropriateness Criteria and Application</b>			
<p>1. What criteria are applied to make a medical necessity/ appropriateness determination and how are they developed or selected? Describe the processes, strategies, evidentiary standards, and other factors applicable to developing/selecting your medical necessity and appropriateness criteria. What are the processes, strategies, evidentiary standards, and other factors applied in assigning medical necessity/ appropriateness reviews to benefits within each classification? What are the written and operating processes, strategies, evidentiary standards, and other factors applied during a medical necessity/ appropriateness review? Specifically address how frequency of review is determined and potential results following such a review.</p>			
<p>2. Do your medical necessity or appropriateness criteria include any of the following:</p>			

Item	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
2A – Fail first requirements or step-therapies (e.g., prescription drugs)? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation for fail first requirements.			
2B – Exclusions based on failure to complete a course of treatment (e.g., tobacco use disorder treatment)? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation for these exclusions.			

Item	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
<b>Prior Authorization</b>			
<p>3. Prior authorization is required prior to coverage of rehabilitative services such as physical therapy. In column 2, describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other outpatient services, and the administration of this requirement. In column 3, describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to psychological testing and any other MH/SUD outpatient services for which prior authorization is required.</p>	<p>The M/S outpatient services that require prior authorization include habilitative and rehabilitative services such as physical therapy. Physical therapy services were selected for prior authorization on the basis of findings that physical therapists' documentation of medical necessity often are inadequate. In addition, there has been an increase in litigation regarding physical therapy claims. Prior authorization is conducted telephonically and authorization determinations are provided verbally and in writing consistent with federal and state timeline requirements. The number of sessions authorized is tailored to the specific M/S condition treated, consistent with Jones and Smith Guidelines. Denial determinations are made by physicians with consultation from a licensed physical therapist.</p>	<p>Psychological testing requires prior authorization. Psychological testing was selected for prior authorization on the basis of recent Medicare fraud schemes and consistent with the Medicare Improper Payment Reports, which found psychological testing claims often were in error because of inadequate documentation from psychologists. Prior authorization is conducted telephonically and reviewed by a licensed psychologist for medical necessity. Authorization determinations are provided in writing consistent with federal and state timeline requirements. The number of hours authorized for psychological testing are tailored to the age of the client and type of evaluation requested, and range from 2 to 5 hours for an average evaluation (on the basis of the average number of hours for evaluation conducted nationally for the last 3 years). Denial determinations are made by licensed psychologists with at least 5 years of experience in psychological testing.</p>	

Item	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
<b>Concurrent Review</b>			
<p>4. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review in each classification? Provide average denial rates and appeal overturn rates for concurrent review in each classification.</p>	<p>Concurrent denial rate for IP: OP: Prescription drugs: Emergency care:</p> <p>Appeal overturn rates for IP: OP: Prescription drugs: Emergency care:</p>	<p>Concurrent denial rate for IP: OP: Prescription drugs: Emergency care:</p> <p>Appeal overturn rates for IP: OP: Prescription drugs: Emergency care:</p>	
<p>5. Identify the factors (e.g., cost of treatment, high cost growth, variability in cost and quality, elasticity of demand, provider discretion in determining diagnosis, type or length of treatment, clinical efficacy of treatment or service, licensing and accreditation of providers, fraud potential) that determine the services selected for concurrent review. What evidentiary standards support their use?</p>			

Item	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
6. For each classification, estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).	Average frequency of concurrent review for IP (exclusive of DRGs or case rates): OP: Prescription drugs: Emergency care:	Average frequency of concurrent review for IP (exclusive of DRGs or case rates): OP: Prescription drugs: Emergency care:	
<b>Prescription Drugs</b>			
7. Are prescription drug benefits tiered? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation that determine how prescription drug benefits are tiered. List the factors that determine the tiers (e.g., cost, brand name vs. generic). Indicate whether the condition treated affects tier assignment of a medication.			

Item	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
<b>Network Admission Requirements</b>			
<p>8. What are your network admission requirements? Describe the written and operational processes, strategies, evidentiary standards, or other factors applied in setting network admission standards and implementing them. Include information regarding network adequacy.</p>			
<p>9. Are any practitioner types (e.g., social workers, recreational therapists), facility types (e.g., chemical dependency facilities, skilled nursing facilities), or specialty providers excluded in writing or in operation from providing covered benefits? If yes, describe the written and operating processes, strategies, evidentiary standards, or other factors applied for this exclusion.</p>			

Item	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
<p>10. Are there any geographic limitations on provider inclusion? If yes, describe the written and operating processes, strategies, evidentiary standards, or other factors applied for this limitation.</p>			
<p>11. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.</p>			
<p>12. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used?</p> <p>On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.</p>			

Item	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
13. Indicate whether and how each of the listed factors affects how professional provider reimbursement rates are determined.	Service type Geographic market Service demand Provider supply Practice size Medicare reimbursement rates Licensure Other	Service type Geographic market Service demand Provider supply Practice size Medicare reimbursement rates Licensure Other	

Abbreviations: DRG, diagnosis-related group; IP, inpatient; MH, mental health; M/S, medical surgical; OP, outpatient; SUD, substance use disorder.



Below are some examples of the types of questions an entity may address in responding to the example NQTL Questionnaires A and B above.

<b>1. Comparability</b>
Describe the NQTL and associated procedures.
What are the requirements of this NQTL? What qualifications or training are required for persons implementing the NQTL?
What is the definition of this NQTL?
Under what circumstances is this NQTL applied?
For what reasons is this benefit subjected to an NQTL?
What is the purpose of applying this NQTL to this benefit(s)?
What is the purpose of applying this NQTL to providers or the network?
What evidence supports the rationale for assignment of this NQTL to the benefit?
What benchmarks are applied in the NQTL decision-making process?
What standards form the basis of the NQTL requirements?
<b>2. Stringency</b>
What consequences/penalties apply when the NQTL is not met? What level of performance is required for each NQTL component (e.g., how many pages in a form; telephonic vs. in-person requirements, number of studies required, days for completion)?
What type and level of evidence is necessary for a benefit to meet the NQTL threshold or for criteria to be adopted?
How much discretion is allowed in applying the NQTL?
Are all benefits in this classification subject to this NQTL?
Describe how medical necessity and appropriateness criteria are reviewed and updated. How and when are new services or technologies added?
How is the frequency of medical necessity and appropriateness reviews determined? What triggers cause a service or item to be reviewed or re-reviewed?
What exception processes are available and when may they be applied?
What evidence supports the frequency with which the NQTL is applied? What evidence supports the severity of the penalty applied? What process measures are in place to assess the stringency with which the NQTL is applied?
What evidence supported the criteria or threshold for decision-making re medical necessity or appropriateness? What benchmarks apply? What outcome measures/standards indicate over or under application of the NQTL?
What evidence supports the criteria for limiting a provider's participation in the network or excluding the provider from the network?

Once initial information is collected, the state will conduct a preliminary comparability and stringency review for each type of NQTL in a classification. If additional information is needed to make a compliance determination, the state will request those data from the applicable entity to supplement the information collected in the tool.

*Tip 6e:* It is recommended that education about parity and the NQTL data collection process be conducted prior to distribution of the first NQTL questionnaire. It is also important to provide the administering entities with adequate time to complete the questionnaire. Finally, because it is likely that additional information will need to be collected after the state reviews initial responses

to the NQTL questionnaire, it is recommended that the state set this expectation with administering entities and incorporate it into applicable timelines.

## 7. Parity Requirements for Medicaid Alternative Benefit Plans (ABPs)

Regardless of whether a state provides ABP benefits through an MCO or an FFS, parity requirements apply. States providing Medicaid ABP benefits through MCOs must meet the parity requirements for Medicaid MCOs at 42 CFR Part 438. If ABP beneficiaries are not enrolled in an MCO, then the parity requirements in 42 CFR 440.395 apply.

*Tip 7a:* If a state contracts with MCOs to provide Medicaid ABP benefits to some beneficiaries and provides Medicaid ABP benefits to other beneficiaries through FFS, then the parity requirements for benefits provided to enrollees of Medicaid MCOs would apply to the Medicaid ABP benefits provided to beneficiaries enrolled in an MCO and the parity requirements for FFS ABPs would apply to benefits provided to beneficiaries not enrolled in an MCO.

Most, but not all, of the parity requirements for Medicaid MCOs apply to FFS ABPs. In particular, the parity requirements for aggregate AL/ADLs do not apply to nonessential health benefit services provided in ABPs (see Table 1 in section 1). However, dollar limits cannot apply to MH/SUD benefits covered as essential health benefits (EHBs). Parity requirements for FRs and treatment limitations (QTLs and NQTLs) and availability of information apply to FFS ABPs.<sup>7</sup>

However, if the state's ABP provides compliant EPSDT benefits, the ABP is deemed to be compliant with the parity requirements for FRs, QTLs, and NQTLs with respect to beneficiaries entitled to EPSDT benefits. Similar to CHIP, described below, the statutory provision applying parity to ABPs requires compliance with both sections 1905(r) and 1902(a)(43) of the Act for deemed compliance (see discussion of CHIP below for information on these sections of the Act).

The documentation of compliance with parity requirements for ABPs is included in the state plan amendment (SPA). States must list any service limitations in the ABP SPA, and the state must ensure, through the benefit descriptions in the ABP5 and ABP7 SPA templates, that it complies with the parity requirements. CMS has reviewed all approved ABP SPAs for parity compliance.

States are responsible for ensuring that ABP benefits are in compliance with parity requirements. CMS will review amendments to ABPs and new ABP SPAs to determine compliance with parity requirements. As a part of the SPA review process, CMS will work closely with states to ensure compliance with the parity requirements and assist states in their efforts to address any inconsistencies discovered during the review process.

For a new ABP state plan application, the submitting state will conduct a parity analysis to determine compliance with parity requirements. A parity analysis from the state also is conducted for an amendment of an approved ABP SPA in instances in which the amendment

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<sup>7</sup> See section 9 of this Toolkit for information regarding availability of information requirements.

would change elements of the benefit package that are considered in a parity compliance determination. For example, states will need to conduct a parity analysis if an amendment to the ABP adds MH or SUD benefits subject to limits or proposes changes to FRs, QTLs, NQTLs, or the availability of plan information. If the SPA proposes limited changes to FRs, QTLs, or NQTLs, a parity analysis may be needed only within the classifications affected by the change.

*Tip 7b:* States must provide documentation of compliance with parity requirements in the ABP SPA. The state verifies compliance through the description of benefits and limitations in ABP5 (Benefits Description), specifically Essential Health Benefits 5 (MH/SUD services).

## 8. Parity Requirements for the Children’s Health Insurance Program (CHIP)

### 8.1 CHIP Overview

All 50 states, DC, and the territories have approved CHIP state plans. There are three plan options under CHIP: Medicaid expansion, separate program, or a combination of both Medicaid expansion and separate program. In addition, in a separate CHIP, states have the option, under Secretary-approved coverage, of modeling their separate CHIP similar to, or identical to, the state’s Medicaid program, including the provision of EPSDT. The majority of states have a combination of Medicaid expansion and a separate program, and some states provide EPSDT in their separate CHIPS. The rules related to parity vary depending on the type of CHIP program that the state has. In addition, the path for meeting parity requirements also will vary depending on whether the state has elected, as part of a separate CHIP program, to provide EPSDT to some or all of its population.

#### 8.1.1 Title XXI-Funded Medicaid Expansions

If a title XXI funded Medicaid expansion program provides services through MCOs, the requirements of 42 CFR Part 438 apply. If a Title XXI–funded Medicaid expansion provides services on an FFS basis with no MCO enrollees, parity does not apply. However, CMS encourages states to comply with parity for all beneficiaries, regardless of whether they are enrolled in an MCO.

#### 8.1.2 Separate Child Health Plans

The statutory provisions applying MHPAEA requirements to CHIPS are structured differently from the statutory provisions applying MHPAEA requirements to coverage to enrollees of Medicaid MCOs. All parity requirements apply to separate child health programs regardless of delivery system, including FFS and capitated managed care. See 42 CFR 457.496. If the state’s delivery system for separate CHIP benefits includes MCOs, PIHPs, or PAHPs, the parity analysis must include coverage provided by MCOs, PIHPs, and PAHPs. The documentation of compliance with parity requirements for separate CHIP programs will be included in the state child health plan. This includes parity requirements for AL/ADLs, FRs, and treatment limitations (QTLs and NQTLs), and availability of information.<sup>8</sup>

CMS will develop a SPA template for states with separate CHIP programs to indicate how the program complies with parity. For child health plans that do not provide full coverage of EPSDT, the template will facilitate the full parity analysis, including the standard for defining M/S and MH/SUD benefits and ensuring compliance with requirements regarding AL/ADLs, FRs, QTLs, NQTLs, and availability of plan information. As a part of the SPA review process, CMS will work closely with states to ensure compliance with the parity requirements and assist states in their efforts to address any inconsistencies discovered during the review process.

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<sup>8</sup> See section 9 of this Toolkit for information regarding availability of information requirements.

Separate CHIPs that do not provide any MH or SUD benefits must submit a SPA to indicate in their child health plan that parity requirements are not applicable.

#### 8.1.2.1 Separate Child Health Plans that Provide EPSDT

Similar to Medicaid ABPs, the statute permits states to request deemed compliance with parity requirements; however, the rules for obtaining this status are different for each program. In order to be considered for deemed compliance, a state must provide certain attestations, descriptions, and supporting documentation to demonstrate that EPSDT benefits under the separate CHIP program meet the statutory provisions specified at section 1905(r) and section 1902(a)(43) of the Act and are provided consistent with the approved Medicaid state plan. States interested in the deeming option also must provide an assurance that the practices associated with NQTLs are permissible under EPSDT requirements at section 1905(r)(5) of the Act and that there are no exclusions of children based on condition, disorder, or diagnosis.

*Tip 8a:* Section 1905(r) of the Act requires states to provide the following:

- Screening services
- Vision, dental, and hearing services
- Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses or conditions discovered during the screening services, regardless of whether the service is covered under the state's Medicaid state plan

Section 1902(a)(43) of the Act requires states to—

- Inform Medicaid beneficiaries under age 21 years about the availability of the full range of EPSDT services
- Provide or arrange for the provision of screening services
- Provide or arrange for treatment

If the state demonstrates that it meets all of these required standards, the state will receive deemed compliance and will *not* need to conduct a parity analysis for the portion of the CHIP population receiving EPSDT. For any children who do not receive EPSDT, the state will need to conduct a parity analysis consistent with requirements in 42 CFR 457.496 for each benefit package, financial requirement, or both applied to other CHIP populations.

## 9. Availability of Information

### 9.1 Introduction

The Medicaid/CHIP parity rule includes two requirements regarding availability of information related to MH/SUD benefits. The first requirement is that the criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries (MCO enrollees and potential enrollees, ABP beneficiaries, and CHIP beneficiaries who are enrollees or potential enrollees with a managed care entity) and affected Medicaid/CHIP providers upon request. The second requirement specifies that the reason for any denial of reimbursement or payment for MH/SUD benefits must be made available to the beneficiary (the MCO enrollee, the ABP beneficiary, or the CHIP beneficiary enrolled with a health plan).

### 9.2 Application to Medicaid MCOs

Both of the requirements for availability of information apply to Medicaid MCOs.

#### *9.2.1 Criteria for Medical Necessity Determination*

If a Medicaid MCO or a PIHP or PAHP providing MH/SUD benefits to a Medicaid MCO enrollee complies with the requirement outlined in 42 CFR 438.236(c) to disseminate practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees, the MCO, PIHP, or PAHP will be deemed compliant with the requirement in 438.915(a) to make the criteria for medical necessity determinations available to enrollees, potential enrollees, and providers upon request. If the state provides MH/SUD benefits on an FFS basis to Medicaid MCO enrollees, it is responsible for making the criteria for medical necessity determinations for MH/SUD benefits available to beneficiaries and providers upon request.

States are encouraged to implement strategies to make medical necessity criteria readily available to beneficiaries and providers and to require MCOs to do the same. Medical necessity criteria should be clearly labeled, searchable, and easy to locate online. When possible, all medical necessity criteria should be available in one location, or if MH/SUD is carved-out, links to those documents should be available. In addition, a phone number should be provided online so that individuals can call to request copies of the medical necessity criteria.

#### *9.2.2 Reason for Denial of Payment*

Although there is no deemed compliance for meeting the requirement to make the reason for any denial of reimbursement or payment for a MH/SUD benefit available to MCO enrollees, if a Medicaid MCO or PIHP or PAHP providing MH/SUD benefits to a Medicaid MCO enrollee provides a notice of adverse benefit determination (consistent with 42 CFR 438.404, including the right of the enrollee to be provided the information specified in 438.404(b)(2)) to enrollees for any denial of reimbursement or payment, that would meet the requirement in 438.915(b) to make the reason for any denial of reimbursement or payment available to enrollees. If the state provides services on an FFS basis to Medicaid MCO enrollees, it is responsible for making the

reason for any denial of reimbursement or payment for a MH/SUD benefit available to beneficiaries.

The state should ensure that when an MCO provides the reason for any denial of reimbursement or payment for a MH/SUD benefit to an enrollee, the reason includes the applicable medical necessity criteria *as applied to that enrollee*. This should include providing any processes, strategies, or evidentiary standards used in applying the medical necessity criteria to that enrollee (see 42 CFR 438.404(b)(2)).

### 9.3 Application to ABPs

If ABP benefits are provided through Medicaid MCOs, then the parity requirements for Medicaid MCOs apply (see section 9.2, Application to Medicaid MCOs).

If ABP benefits are provided to beneficiaries not enrolled in a Medicaid MCO, then the state is responsible for making the criteria for medical necessity determinations for MH/SUD benefits made by the state available to any beneficiary or Medicaid provider upon request and making the reason for any denial of reimbursement or payment for an MH/SUD benefit available to beneficiaries.

### 9.4 Application to CHIP

For benefits in a separate CHIP program, the managed care entity (MCE)<sup>9</sup> or the state is responsible for making the criteria for medical necessity determinations for MH/SUD benefits made under the child health plan available to any potential or current enrollee or contracting provider upon request. If the MCE complies with the requirement in 42 CFR 438.236 regarding dissemination of practice guidelines, the MCE will be deemed compliant with the requirement to make the criteria for medical necessity determinations available to beneficiaries and providers.

The MCE or the state must make the reason for any denial under a health plan of reimbursement or payment for MH/SUD benefits available to the enrollee. These requirements are already met by complying with existing notification and disclosure requirements in 42 CFR 457.110 and 457.1130.

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<sup>9</sup> *Managed care entity* means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to MCOs, prepaid health plans, and primary care case managers. See 42 CFR 457.10.



## **10. Key Abbreviations**

ABP = alternative benefit plan

AL/ADL = aggregate lifetime and annual dollar limits

CHIP = Children's Health Insurance Program

CMS = Centers for Medicare & Medicaid Services

DSM = Diagnostic and Statistical Manual of Mental Disorders

EPSDT = Early and Periodic Screening, Diagnostic and Treatment

FFS = fee-for-service

FR = financial requirements

ICD = International Classification of Diseases

LTSS = long term services and supports

MCE = managed care entity

MCO = managed care organization

MH = mental health

MHPAEA = Mental Health Parity and Addiction Equity Act of 2008

M/S = medical/surgical

NQTL = non-quantitative treatment limitation

PAHP = Prepaid Ambulatory Health Plan

PIHP = Prepaid Inpatient Health Plan

QTL = quantitative treatment limitation

SPA = state plan amendment

SUD = substance use disorder