OKLAHOMA

QTL REPORTING INSTRUCTIONS

Each insurer that offers, issues, or renews any individual or group health benefit plan providing mental health or substance use disorder benefits shall submit an ANNUAL REPORT to the Oklahoma Insurance Department ON or BEFORE April 1 of each year. *36 O.S.§6060.11.* The reporting templates shall be e-mailed to MHPtemplate@oid.ok.gov.

All Excel reporting templates should be named/saved using the following file naming convention:

QTL or NQTL/Year/NAIC #

Example: QTL202012345.xlsx

The following template shall be used to report Quantitative Treatment Limitation and Financial Requirement (QTL) testing outcomes to the Department by the April 1 deadline.

QTL/Financial Requirement Template Instructions

The information requested in this template will assist in determining a plan's compliance with benefit classification requirements and Quantitative Treatment Limitation and Financial Requirement (QTL) testing outcomes required under the Mental Health Parity and Addiction Equity Act (MHPAEA). As an initial step, identification of all covered services, both medical/surgical and MH/SUD, is critical for complete QTL and NQTL analyses. Classification of covered services must remain consistent across both types of analysis, thus must be established at the outset.

Covered Services Tab

Step 1. Provide the requested Company Name, Plan Name/ID, Plan Year, and Coverage Type (i.e., HMO, PPO, EPO, POS, etc.), and select the appropriate dropdown box (large group, small group, or individual) for the Plan Market information.

Cell	**Notes on Response**
C2	Company Name
C3	Plan Name/ID (e.g., HIOS #)
C4	Plan Year
E4	Select from Dropdown (Small, Large, Individual)
F4	Provide Coverage type

Step 2. **Answer the following questions by selecting either Yes or No in the appropriate dropdown box:**

- **Are outpatient services sub-classified into "office visit" and "other"?**
  - This question must be answered in order to populate the classification cells in column E. Answering yes will populate a drop-down menu with subclassification options; answering no will populate a drop-down menu with the six listed classifications.
- **Is there a tiered network?** If Yes, continue to the next question. If no, move to Step 3.
- **If yes, please select the number of tiers:** Select the appropriate number of tiers from the dropdown box.
  - **NOTE: "Tiered network" refers to multiple levels of tiering with respect to contracted providers. Out-of-network is not considered a tier.**
- **NOTE: This template does not automatically separate multiple networks for purposes of analysis.**
  - **Any covered services that allow for use of multiple provider tiers should be separated out into separate rows and identified each tier (see example below).**
  - **If the company chose to subclassify based on networks (pursuant to *45 C.F.R. §146.136(c)(3)(iii)(B)),* the analysis will have to be completed manually as described below.**

Cell	Notes on Response
E6	Select from Dropdown: Yes or No regarding outpatient sub-classification
E7	Select from Dropdown: Yes or No regarding tiering
E8	If Yes above, select number of tiers (excluding out-of-network)

Step 3. List all Covered Services in Column B

Cell	Notes on Response
Beginning with B10	List all Covered Services

- All services included in Certificates of Coverage and Schedules of Benefits should be identifiable in the list of covered services.
- Covered services should have their own row based on classification, network (in and out, as well as tiering if applicable), cost-sharing type, applicable FR or QTL (i.e., cost sharing and visit or day limits), and FR or QTL level.
- Covered services that match in benefit type (MH/SUD or Med/Surg), classification/sub-classification, FR type and level, and QTL type and level can be rolled into a single line.

Example 1 - Network: Include a separate covered service row for services that are covered in-network and out-of-network, e.g., one row for PCP office visit-in network, and a separate row for PCP office visit-out of network.

Covered Services	Medical/Surgical or MH/SUD	Expected Claim Dollar Amount	Classification
PCP Office Visit, In-network	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
Specialist Office Visit, In-network	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
PCP Office Visit, Out-of-network	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office
Specialist Office Visit, Out-of-network	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office

Example 2 - Network: Services should be separated by tier when there is more than one network tier, e.g., preferred specialist on one row, non-preferred specialist in a separate row.

Covered Services	Medical/Surgical or MH/SUD	Expected Claim Dollar Amount	Classification
PCP Office Visit, Preferred Tier	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
PCP Office Visit, Non-preferred Tier	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
PCP Office Visit, Out-of-network	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office

Example 3 - Cost-Sharing: Include a separate covered service line for services that have different cost sharing that is dependent upon site of service or diagnostic vs. preventive. For example, CDC-recommended immunizations are $0 cost-sharing but may be provided in a PCP's office or at a pharmacy, while other immunizations (e.g., for travel) may be provided by a PCP but may have cost-sharing applied. Each instance would need to have its own row for reporting covered services.

Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
Immunizations - ACA preventive - PCP office	Med/Surg	$xx,xxx,xxx	OutPt, IN-Office
Immunizations - non-ACA preventive - PCP office	Med/Surg	$xx,xxx,xxx	OutPt, IN-Office
Immunizations - ACA preventive - non-PCP	Med/Surg	$xx,xxx,xxx	OutPt, IN-Other

Example 4 - Classification: For purposes of MHPAEA analysis, classification of benefits, and any corresponding limitations, should be based on the underlying diagnosis, regardless of site of service or the system through which claims are processed. For example, occupational therapy may be appropriate for both medical/surgical and MH/SUD diagnoses, and processed through a medical claims system. For purposes of the analysis, however, the occupational therapy claims processed for underlying medical/surgical diagnoses should be classified as medical/surgical and occupational therapy processed for underlying MH/SUD (e.g., ADHD, Autism, as defined in product information) should be classified as MH/SUD.

Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
Occupational Therapy - office	Med/Surg	$xxx,xxx,xxx	OutPt, IN-Office
Occupational Therapy - ADHD office	MH/SUD		OutPt, IN-Office
Occupational Therapy - ASD office	MH/SUD		OutPt, IN-Office
Occupational Therapy - ASD community	MH/SUD		OutPt, IN-Other

and

Covered Services	Medical/Surgical or MH/SUD	Expected Claim Dollar Amount	Classification
Speech therapy, ASD	MH/SUD		OutPt, IN-Office
Speech therapy, Medical/Surgical	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
Speech therapy, ASD	MH/SUD		OutPt, OON-Office
Speech therapy, Medical/Surgical	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office

Step 4. Designate whether each covered service is Medical/Surgical or MH/SUD in Column C, **taking the following into consideration:**

- Services must be identified as medical/surgical or MH/SUD as defined under the terms of the plan and in accordance with applicable state and federal law. Any condition defined by the plan as being medical/surgical or MH/SUD must be consistent with generally recognized independent standards of current medical practice (e.g., the most current version of the ICD or State guidelines).
- Once defined as medical/surgical or MH/SUD, the Company's definition must remain consistent for all MHPAEA analyses for each plan within the product being analyzed, i.e., QTL and NQTL analyses.
- NOTE: Every medical/surgical service classification must have MH/SUD covered services **in that same classification.** *45 C.F.R. § 146.136(c)(2)(ii)(A).*

Cell	Notes on Response
Beginning with C10	Select from Dropdown: Medical/surgical or MH/SUD for each Covered Service listed in Column B

Step 5. Enter Expected Claim Dollar Amounts in Column D for each listed covered service that is identified as medical/surgical. The template auto-fills the cells for Expected Claim Dollar Amounts with red, as those dollar amounts are not necessary.

- All covered medical/surgical services, including those services with zero-dollar cost sharing for members, must have an associated expected plan claim dollar amount listed. Also, expected claim dollar amounts must be based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year; expected claim dollar amounts do not include cost sharing amounts paid by members.

Cell	Notes on Response
Beginning with D10	List expected claim dollar amount for each Covered Service listed in Column B

Step 6. Choose the appropriate Classification or Sub-Classification in Column E **by selecting the appropriate responses in the dropdown boxes.**

- Services should be classified consistently regardless of ACA requirements, e.g., Mammography (preventive/screening) and Mammography (diagnostic or non-screening) should be included in the same classification since the service is the same regardless of whether it is an ACA covered preventive mammogram or a diagnostic mammogram. They would require separate rows, however, due to the difference in cost-sharing.

- For outpatient services, location of service may be a permissible distinction, e.g., immunizations in PCP's office may be placed in the outpatient, office visit subclassification while immunizations in a pharmacy may be placed in the outpatient, all other subclassification.
- Similar services should be classified together unless the location or other distinction can be identified, e.g., breastfeeding supplies and diabetic supplies may be in the same classification unless diabetic supplies are covered under pharmacy benefits and breastfeeding supplies are considered DME.

Cell	Notes on Response
Beginning with E10	Select classification or sub-classification from dropdown for each Covered Service listed in Column B

Step 7. In Column F and Column G, provide citations in the form of page numbers and sections in both the Certificate of Coverage and Schedule of Benefits where the services included in each line of the listed Covered Services can be found.

- This information will allow regulators to determine the specific services from Certificates of Coverage and Schedules of Benefits that are included in each line of Covered Services.

Cell	Notes on Response
Beginning with F10	List COC page number related to each Covered Service listed in Column B
Beginning with G10	List SOB page number related to each Covered Service listed in Column B

COC Cites:	SOB Cites:
pg. 14, Section III	pg. 3, Section II
pg. 25, Section V	pg. 4, Section III

Analysis Tabs

Data entered in columns B through G will auto-populate the corresponding tabs for purposes of reporting QTLs and Financial Requirements.

For each tab, enter the corresponding cost-sharing or visit limit information in the lines with covered services. Where limits are not applied or the cost-sharing is $0, enter "N."

- Note that only medical/surgical services carry over to the calculation tabs.

Service Categories within the Sub-Classification of: OPTION-OUTPATIENT, IN, OFFICE	COLUMN 1 EXPECTED CLAIM DOLLAR AMOUNT	COLUMN 2 COPAY APPLICATION	COLUMN 3 COINSURANCE APPLICATION	COLUMN 4 DEDUCTIBLE APPLICATION	COLUMN 5 SESSION LIMITS APPLICATION
INSTRUCTIONS: All MEDICAL/SURGICAL service categories provided within this sub-classification are listed below.	INSTRUCTIONS: List Claim Expected Allowed Dollar Amounts (Annual) for each service category listed.	INSTRUCTIONS: Is a copay applied to this service category? If yes, list the copay dollar amount applied to the Service Category. If no, put a "N" for every Service Category where there is no copay application.	INSTRUCTIONS: Is a coinsurance applied to this service category? If yes, list coinsurance Percentage Amount Applied to the Service Category. If no, put a "N" for every Service Category where there is no coinsurance application.	INSTRUCTIONS: Is a deductible applied to this service category? If yes, put a "Y" for every Service Category with a deductible application. If no, put a "N" for every Service Category where there is no deductible application.	INSTRUCTIONS: Is a session limit applied to this service category? If yes, put the session limit for every Service Category. If no, put a "N" for every Service Category where there is no session limit application.
Occupational Therapy - office	$45,545,522.00	$40.00	N	N	N
Speech Therapy - office	$48,552,679.00	$40.00	N	N	N
Immunization- ACA - PCP office	$1,525,588.00	N	N	N	N
Immunization - Travel - PCP office	$544,899.00	$25.00	N	N	N

When Columns 2-6 (D-H) are filled out, formulas will auto-calculate the substantially all and predominant level tests. The user will be prompted if the substantially all threshold is not met and which level is the predominant level, if applicable.

MEDICAL DIRECTOR/OFFICER AFFIDAVIT

In addition to the above requirements, at least one (1) medical director or officer of the reporting company must review and sign an affidavit verifying the template(s) are accurately and properly filled out, satisfying the reporting requirements of 36 O.S. §6060.11. *Example:*

I, *(Name of Medical Director/Officer),* certify that the attached template(s) have been thoroughly completed and reviewed, thereby accurately complying with reporting required by *36 O.S. §6060.11.*

_____
(Name of Medical Director/Officer)
MEDICAL DIRECTOR/OFFICER

SUBSCRIBED AND SWORN TO before me this _____ day of April, 2021.

_____
Notary Public

My Commission Expires: _____

My Commission Number: _____

[SEAL]