MHPAEA QTL Spreadsheet Instructions

1. Start in the "Covered Services" worksheet/tab.

A	В	с	D	E	F	G	Н	1	S	т
2 3	Company: Plan Name/ID:			Small, Large or Individual Market?	Coverage type? (HMO, PPO, EPO, POS, etc)					
4	Plan Year:			Select						
5				*Select Option From Drop Down Boxes Below*						
6	Are outpatient serv	Are outpatient services sub-classified into "office visit" and "other"?		Select						
7			Is this a tiered network?	Select						
8		If "yes", pleas	e select the number of tiers:	Select (If Applicable)	Please provide the page numbers and sec found within both o	tions where each covered service may be of these documents.				
9	Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification	COC Cites:	SOB Cites:				
10										
11										
12										
14										
15										
16										
17							1			
18										
19										
20										
21										
23										
24										
25										
26										
27	Y									
28	V						-			
25		l .	l	l		l	-			
	Covered Services INPATIENT, IN-NETWORK INPATIENT, OUT-OF-NE	TWORK OUTPAT	IENT, OUT-OF-NETWORK	OUTPATIENT, IN-NETWORK	0 🕀 🗄 🖣					Þ

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2. In cells C2, C3, and C4, enter the Company, Plan Name/ID, and Plan Year.

A	B	С	D	E	F
2 3 4	Company: Plan Name/UD: Plan Year:			Small, Large or Individual Market? Select	Coverage type? (HMO, PPO, EPO, POS, etc)
5				*Select Option From Drop Down Boxes Below*	
6	Are outpatient serv	ices sub-classified int	o "office visit" and "other"?	Select	
7			Is this a tiered network?	Select	
8		If "yes", pleas	e select the number of tiers:	Select (If Applicable)	Please provide the <u>page numbers and sec</u> found within both o
9	Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification	COC Cites:
10					
11					
12					
13					
14					
15					

3. In cell E4, complete the drop-down box based on whether the plan is for Small Group, Large Group, or Individual Market.

2

	С	D	E	F
Company: Plan Name/ID:			Small, Large or Individual Market?	Coverage type? (HMO, PPO, EPO, POS, etc)
Plan Year:			Select	5
Are outpatient serv	ices sub-classified in	to "office visit" and "other"?	Select Individual Small Group Large Group Select	
		Is this a tiered network?	Select	
	If "yes", pleas	se select the number of tiers:	Select (If Applicable)	Please provide the <u>page numbers and sec</u> found within both o
	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification	COC Cites:

4. In cell F4, enter the coverage type (HMO, PPO, EPO, etc.).

E	F
Small, Large or Individual Market?	Coverage type? (HMO, PPO, EPO, POS, etc)
Select	
Select Option From Drop Down Boxes Below	
Select	
Select	
Select (If Applicable)	Please provide the <u>page numbers and sec</u> found within both o

 Complete the drop-down boxes in cells E6, E7, and E8 based on whether the plan involves outpatient sub-classifications for "office visit" and "other" and whether the plan involves a tiered network:

3

See 45 CFR 146.136 (c)(3)(iii)(C) and 45 CFR 146.136 (c)(3)(iii)(B).



6. List all Medical/Surgical and MH/SUD covered services in column B.



7. FOR MULTI-TIERED NETWORKS ONLY:

Please include a separate service line for services separated by tier, e.g. preferred specialist on one-line, non-preferred specialist on a separate line.



8. Select the drop down in column C to indicate if the covered service was for a Medical/Surgical or MH/SUD diagnosis/condition.



 List the expected claim dollar amount in column D. This is for benefits related to Medical/Surgical diagnoses/conditions only.



10. Select the classification from the drop-down box in columnE.



11. Reference COC and SOB page numbers and sections where the corresponding covered services are found in columns F and G.



12. Once the information has been entered in the "Covered Services" worksheet/tab, the other worksheets/tabs for each classification will auto-populate with the covered services and expected claim dollar amounts.

8

A	В	С	D	E	F	G
1	SUBSTANTIALLY ALL TEST- 45 CFR 146.136 (c)(3)(i)(A): 5 that classification. (For this purpose, benefits expressed as subject to treatment limitation.) If a type of financial requirement or quantitat	ubstantially all. For purposes of this paragraph > a zero level of a type of financial requirement ve treatment limitation does not apply to at lea	(c), a type of financial requirement or quantitati are treated as benefits not subject to that type st two-thirds of all medical/surgical benefits in	ve treatment limitation is considered to apply to sub of financial requirement, and benefits expressed as s a classification, then that type cannot be applied to r	stantially all medical/surgical benefits in a class ubject to a quantitative treatment limitation th nental health or substance use disorder benefit	ification of benefits if it applies to a at is unlimited are treated as benef s in that classification.
2	Plan:				Plan Year:	
з	Service Categories within the Classification of:	COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
4	INPATIENT, IN-NETWORK	EXPECTED CLAIM DOLLAR AMOUNT	COPAY APPLICATION	COINSURANCE APPLICATION	DEDUCTIBLE APPLICATION	SESSION LIMITS APPLICATION
5	INSTRUCTIONS: All MEDICAL/SURGICAL service categories provided within this 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 "V" 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 lin applied to this service categor yes, put the session limit for e Service Category. If no, put a " every Service Category where no session limit application.
6	Covered Service A	\$10,000,00	1 P. P.			
7	Covered Service C	\$20,000.00				
8	Covered Service D	\$30,000.00				
9						
10						
11						
12						
13						
14						
15						
16						
1/						
10						
19	L	l	I		1	
	Covered Services INPATIENT, IN-NETWORK INPATIEN	T, OUT-OF-NETWORK OUTPATIENT, OUT-OF	-NETWORK OUTPATIENT, IN-NETWORK	O (+) : (4)		F

13. Complete Column 1 through Column 6 in each of the applicable classification worksheets/tabs.

c), a type of financial quirement or quantitative treatment limitation is considered to apply to substantially all medice surgical benefits in a classification of benefit if it applies to at least two-thirds of all m lical/surgical be it are treated as ben. Its not subject to that type of financial requirem int, and benefits expressed as subject to a quan ative treatment limitation that is unlimite are treated as benefits not subject to that type of quantities attro-thirds of the rest treatment limitation tasking into the rest tasking into the rest of the rest treatment limitation tasking into the rest of the rest treatment limitation tasking into the rest treatment limitation tasking into the rest tasking into taski							
↓ ·	Ļ	Plan Year:	↓ I	↓ I			
COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6			
COPAY APPLICATION	COINSURANCE APPLICATION	DEDUCTIBLE APPLICATION	SESSION LIMITS APPLICATION	DAY LIMITS APPLICATION			
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.	INSTRUCTIONS: Is a day limit ap to this service category? If yes, the day limit for every Service Category. If no put a "N" for ev Service Category where there i day limit application.			
		1	1				

14. In the worksheet/tab for each classification, Cell C66 provides instructions to interpret the results of the substantially all test. Cells D67 through H67 will tell you if the substantially all threshold has been met.

A	В	С	D
	Plan:		
2			
3	Service Categories within the Classification of:	COLUMN 1	COLUMN 2
4	INPATIENT, IN-NETWORK	EXPECTED CLAIM DOLLAR AMOUNT	COPAY APPLICATION
			INSTRUCTIONS: Is a copay applied to this
		INCTRUCTIONS	service category? If yes, list the copay
		List Claim Expected Allowed Dollar	Category If po, put a "N" for every
	All MEDICAL/SUBGICAL service categories provided within	Amounts (Annual) for each service	Service Category where there is no conav
5	this classification are listed below.	category listed.	application.
6	Covered Service A	\$10,000.00	\$20.00
7	Covered Service C	\$20,000.00	\$30.00
8	Covered Service D	\$30,000.00	\$20.00
62			
			For every row in COLUMN 2 with an
	AGGREGATE TOTAL OF MEDICAL AND SURGICAL BENEFITS		amount listed, ADD the expected claim
	EXPECTED CLAIM DOLLAR AMOUNT WITHIN THIS		dollar amounts (COLUMN 1) for the
63	CLASSIFICATION	\$60,000.00	service category listed within that row.
64		AGGREGATE TOTALS	\$60,000.00
			DIVIDE the AGGREGATE TOTAL of all rows
			with COPAY listed (COLUMN 2),
6F			Indicating copay is applied, by the
05		If the amount listed within this saw is	Addredate for a bi colomin 1.
		if the unbuilt listed within this row is not areater than or equal to $2/3$ or	
		66.67% the OTL cannot be applied for	
66		this plan desian.	100.00%
67			Threshold Met
	PREDOMINANT TEST- 45 CFR 146.136 (c)(3)(i)(B): Pred	ominant - If a type of financial requirement or	quantitative treatment limitation applies to at
	(c)(3)(i)(A) of this section, the level of the financial requirement or	quantitative treatment limitation that is consid	lered the predominant level of that type in a c
68	In that classification subject to the milancial requirement or quantit	alive treatment limitation.	
		1	
			PERCENT (%) OF CLASSIFICATION
-	Covered Services INPATIENT, IN-NETWO	ORK INPATIENT, OUT-OF-NETWORK	OUTPATIENT, OUT-OF-NETWOR

15.Starting in row 68, columns E and F provide instructions to interpret the results of the predominant test for the level of financial requirement/QTL. A cell in column F will auto-populate with "Predominant Level Met" at the level which passes the predominant test. For example, the image below shows the predominant level being met at the \$20.00 copay level.

68	PREDOMINANT TEST- 45 CFR 146.136 (c)(5)(0)(6): Predominant - If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a dassification as determined under paragraph (c)(3)(0)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a dassification of benefits is the level that applies to more than one-half of medical/surgical benefits in that dassification subject to the financial requirement or quantitative treatment limitation.						
				START HERE, MOVE DOWNWARD ONE			
			REPORT (%) OF CLASSIFICATION	LEVEL ONTIL AGGREGATE TOTAL OF			
			APPLIED AT THIS LEVEL	IS THE PREDOMINANT LEVEL, AND THE	NOTE: If any of the levels individually reach over		
	LEVELS OF COPAYS,	TOTAL EXPECTED CLAIM DOLLARS	[LEVEL \$ AMOUNT DIVIDED BY	HIGHEST LEVEL THAT CAN BE APPLIED	50.01%, that level may be applied to MH/SUD		
69	LOWEST TO HIGHEST	APPLIED AT THIS COPAY LEVEL	TOTAL A \$]	TO MH/SUD BENEFITS.	appropriate level.		
70	\$20.00	\$50,000.00	83.33%	83.33%	Predominant Level Met		
71	\$30.00	\$10,000.00	16.67%	100.00%	_		
72				0.00%			
73				0.00%	_		
74				0.00%	_		
75				0.00%	_		
76	TOTAL A:	\$ 60,000.00					
77							
				START HERE, MOVE DOWNWARD ONE			
				LEVEL UNTIL AGGREGATE TOTAL OF			
	PERCENT (%) OF CLASSIFICATION LEVELS REACH OVER 50.01%; STOP. THAT						
		TOTAL EXPECTED CLAIM DOLLARS	APPLIED AT THIS LEVEL	IS THE PREDOMINANT LEVEL, AND THE	50.01%, that level may be applied to MH/SUD		
70	LEVELS OF COINSURANCE,	APPLIED AT THIS COINSURANCE	LEVEL \$ AMOUNT DIVIDED BY	HIGHEST LEVEL THAT CAN BE APPLIED	benefits. Otherwise, use chart to determine		
78	LOWEST TO HIGHEST	LEVEL	IOTAL B \$]	TO WIR/SOD BENEFITS.	appropriate ievei.		
	Covered Services INPATIENT, IN-NETWORK INPATIENT, OUT-OF-NETWORK OUTPATIENT, OUT-OF-NETWORK OUTPATIENT, IN-NETWORK O 💮 : 🗨						