

2026 Nonquantitative Treatment Limitation (NQTL) Submission Template

Instructions: This NQTL reporting submission form includes the required six information elements or Required Steps as specified by the Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations, including 42 USC Section 300gg-26(a)(8)(A) and 45 CFR 146.137. The comparative analyses to be performed must be reported using this submission form and should comply with MHPAEA, its regulations, federal guidance, and the instructions, both separately provided and set forth herein.

A separate reporting form should be prepared and completed for each NQTL requested by the BOI in each benefits classification/sub-classification. For example, the comparative analysis for prior authorization for the Inpatient, In-Network benefits classification should be provided on its own reporting submission form, and the comparative analysis for prior authorization for the Inpatient, Out-of-Network classification should be provided in a separate reporting submission form. Similarly, the comparative analyses for prior authorization for Outpatient benefits should be reported separately, with a form used for In-Network and a form to be used for Out-of-Network. If there are questions about how to properly report using this form, please contact the BOI.

In-Network Outpatient Provider Reimbursement

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See [45 CFR 146.137\(c\)\(1\)](#). Step 1 must include the following:

- (i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;
- (ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and
- (iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also [FAQ 45](#) (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and

- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

This comparative analysis addresses the In-Network (INN) Outpatient Provider Reimbursement NQTL applied to mental health/substance use disorder (“MH/SUD”) and medical/surgical (“M/S”) benefits within the outpatient benefit classifications and is incorporated in plans insured by Cigna Health and Life Insurance Company (“CHLIC”). The NQTL consists of the processes, strategies and methodologies used to establish, negotiate, approve and apply reimbursement rates for participating outpatient facilities and practitioners, including the selection of applicable reimbursement methodologies and fee schedules and the evaluation and approval of provider-specific or non-standard reimbursement arrangements. In the preparation of the analysis of the In-Network (INN) Outpatient Provider Reimbursement NQTL, Cigna reviewed the applicable CHLIC and Evernorth Behavioral Health (“EBH”) reimbursement policies and procedures, supporting methodology, documents, provider contracting requirements and relevant provisions of the Connect Bronze 6500 Indiv Med Deductible plan certificate.

EBH an affiliate of CHLIC, manages the network for MH/SUD benefits, while CHLIC manages the network for M/S benefits. All entities collectively referred to as “Cigna” and references to “Cigna” or “Cigna Network” contained herein include Evernorth Behavioral Health Network unless otherwise noted separately.

No third parties or separate related entities played a role in developing the NQTL, its comparative analysis, or the policies and procedures contained in this response. Cigna maintains corporate-wide policies applicable to its multiple business segments including Cigna Healthcare (applicable to M/S services) and Evernorth Behavioral Health (applicable to MH/SUD services), and policies applicable to specific business segments only (either M/S or MH/SUD services).

Cigna has assessed several components of its standards for a provider and/or facility reimbursement (collectively “Provider Reimbursement”) NQTL applicable to the INN outpatient benefit classification for M/S and MH/SUD services.

Unless otherwise expressly stated, all information provided in Step 1 applies equally to the Base Rates, Final Rates, and Adjusted Rates, as defined by Virginia, described in this comparative analysis.

The plan language or coverage terms governing In-Network Outpatient Provider Including Facility Reimbursement is excerpted from Connect Bronze 6500 Indiv Med Deductible plan certificate and states as follows:

Connect Bronze 6500 Indiv Med Deductible Plan Language
Participating Provider/In-Network Provider means: ▪ Hospitals, Physicians, and Other Health Care Facilities or Professionals which are: (i) licensed in accordance with any applicable federal and state laws, (ii) accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if approved by Cigna Healthcare, and (iii) acting within the scope of the practitioner’s license and accreditation, and have contracted with Cigna Healthcare to provide services to Insured Persons; or

- For the purposes of reimbursement for Covered Expenses, an entity that has contracted with Cigna Healthcare to arrange, through contracts with Providers for the provision of any services and/or supplies, the Charges for which are Covered Expenses.¹

Allowable Expense

The portion of a Covered Expense used in determining the benefits this plan pays when it is the Secondary Plan. The Allowable Expense is the lesser of:

- the charge used by the Primary Plan in determining the benefits it pays;
- the charge that would be used by this plan in determining the benefits it would pay if it were the Primary Plan; and
- the amount of the Covered Expense.

If the benefits for a Covered Expense under your Primary Plan are reduced because you did not comply with the Primary Plan's requirements (for example, getting pre-certification of Hospital admission or a second surgical opinion), the amount of the Allowable Expense is reduced by the amount of the reduction.²

Charges means the actual billed charges, except when the Provider has contracted with Cigna Healthcare for a different amount, including where Cigna Healthcare has contracted with an entity to arrange for the provision of Covered Services through contracts with Providers of such services and/or supplies.

Covered Expenses are the expenses incurred for Covered Services under this Policy which Cigna Healthcare will consider for payment under this Policy. Covered Expenses are:

- the Negotiated Rate for Covered Services from Participating Providers.
- the Allowed Expense for Covered Services from Non-Participating Providers.

As determined by Cigna Healthcare, Covered Expenses will include all charges made by an entity that has contracted with Cigna Healthcare to arrange, through contracts with Providers, for the provision of any Covered Services.

Covered Expenses may be limited by other specific maximums described in this Policy. Covered Expenses are subject to applicable Deductibles and other benefit limits. **An expense is incurred on the date the Insured Person receives the service or supply.** Covered Expenses may be less than the amount that is actually billed³

Description of the NQTL:

The In-Network (INN) Outpatient Provider Reimbursement NQTL consists of the processes, strategies and methodologies Cigna utilizes to establish, negotiate, approve and apply network reimbursement rates, for participating outpatient providers and facilities. It includes the selection and use of standard or provider-specific fee schedules; provider classification by type, specialty, licensure, and facility or practitioner status; applicable reimbursement methodologies and benchmarks; and the factors, evidentiary standards, documentation, escalation, and approval requirements used to evaluate non-standard rates. The NQTL applies to M/S and MH/SUD benefits in the In-Network Outpatient—Office and In-Network Outpatient—All Other classifications. It governs the framework for determining reimbursement; it does not prescribe a uniform payment amount or require identical negotiated outcomes across providers, facilities, services, or markets.

Provider Types and Payment Structures:

- INN Outpatient Facility services billed on an institutional basis are reimbursed under the applicable facility reimbursement methodology or provider-specific negotiated arrangement.
- INN Outpatient Professional services rendered by physicians or other practitioners in an outpatient place of service are reimbursed under the applicable professional fee schedule or provider-specific negotiated arrangement.

¹ Connect Bronze 6500 Indiv Med Deductible Plan Booklet pg. 31 of 112

² Connect Bronze 6500 Indiv Med Deductible Plan Booklet pg. 92 of 112

³ Connect Bronze 6500 Indiv Med Deductible Plan Booklet pg. 23 of 112

Other Payment Models:

Cigna does not utilize capitation, salary-based reimbursement or bundled compensations arrangements models in its reimbursement of M/S or MH/SUD INN Outpatient facilities or practitioners. Cigna does not own the facilities included in this analysis and does not employ the participating practitioners whose reimbursement is evaluated in this NQTL analysis. Accordingly, facility ownership or practitioner employment relationships do not impact the reimbursement methodologies described herein.

Glossary:

1. Allowed Expense: is the amount that Cigna may cover for services rendered by a Participating Provider consistent with applicable law.
2. Charges: means the actual billed charges, except when the Provider has contracted with Cigna for a different amount, including where Cigna has contracted with an entity to arrange for the provision of Covered Services through contracts with Providers of such services and/or supplies.
3. Ambulatory Payment Classification (APC): Is a Medicare payment system used for hospital outpatient services. It groups services that require similar resources and clinical characteristics, assigning each group a payment rate based on the average cost of services within that group.
4. Ambulatory Surgical Center (ASC): Is a Medicare payment methodology for facility-based services provided in Ambulatory Surgical Centers (ASCs) for outpatient surgical procedures. This payment methodology utilizes a value-based, prospective payment system that determines how much an ASC is paid for each covered procedure, regardless of the actual cost incurred.
5. Coordination of Benefits (COB): A process used to determine how payment responsibility is allocated when a covered individual has coverage under more than one health plan or payer. COB information from other carriers may be used, where available, to understand reimbursement paid by another payer and to support assessment of competitive or fair-market reimbursement levels.
6. Facility (outpatient): A Hospital or Free-Standing Facility that provides Health Care Services but does not require an overnight stay.
7. Mental Health or Substance Use Disorder (MH/SUD): Means benefits with respect to items or services for mental health conditions or substance use disorders that are included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as defined under the term of the plan and in accordance with applicable federal and state law. Any condition defined by the plan 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 International Classification of Diseases (ICD), or state guidelines).
8. Medical/Surgical (M/S): Means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan and in accordance with applicable federal and state law but does not include mental health or substance use disorder benefits. Any condition defined by the plan 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).
9. Negotiated Rate: is the lesser of billed Charges or the rate of payment that has been negotiated with a Participating Provider for Covered Services.
10. Participating Provider/In-Network Provider means:
 - Hospitals, Physicians, and Other Health Care Facilities or Professionals which are: (i) licensed in accordance with any applicable federal and state laws, (ii) accredited by

the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if approved by Cigna, and (iii) acting within the scope of the practitioner's license and accreditation, and have contracted with Cigna to provide services to Members; or

- For the purposes of reimbursement for Covered Expenses, an entity that has contracted with Cigna to arrange, through contracts with Providers for the provision of any services and/or supplies, the charges for which are Covered Expenses. Provider agreement in effect with Cigna for this EOC at the time services are rendered.

11. Provider/Practitioner: A licensed physician, non-physician health care practitioner, hospital or other facility, supplier, or other individual or entity involved in the delivery of health care services or benefits.
12. Qualifying Payment Amount (QPA): The median contracted rate recognized by the plan (determined by all plans/coverage offered by the plan/issuer in the same market, e.g. individual, small group, large group, self-insured group plans) as the total maximum payment provided on January 31, 2019 (or the previous year, for 2023+ plan years), for the same or similar item or service, by a similar provider, in the same geographic region.
13. Relative Value Unit (RVU): Is a system used in the United States to determine physician reimbursement rates for the services they provide. RVUs are a component of the Resource-Based Relative Value Scale (RBRVS), which is utilized by Medicare and private payers to establish payment amounts based on the resources and effort required for medical services.
14. Resource-Based Relative Value Scale (RBRVS): a CMS-created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates.
15. Transparency Data: Publicly available or disclosed pricing information made available under applicable federal transparency requirements, including the No Surprises Act and related transparency provisions. This data may include negotiated in-network rates, historical allowed amounts, provider identifiers, billing codes, service descriptions, and other information relevant to evaluating market reimbursement.

Supporting Documents:

Document/Policy Name	Description
Connect Bronze 6500 Indiv Med Deductible Plan Booklet	Plan specific document that outlines the details of a health insurance plan, including plan and benefit information, claim review procedures, and participation rights. The plan booklet provides comprehensive information about what the plan covers, how it is administered, and the procedures for reviewing claims. It is intended to help members understand their rights and responsibilities under the plan.
HM-NET-010 Fee Exceptions Policy	Outline in-network MH/SUD process for granting exceptions to the standard fee schedules for outpatient clinics and individual providers.
HM-NET-011 Provider Fee Schedules Policy	Set forth guidelines for the consistent application of in-network standard fee schedules across the provider network specific to MH/SUD.
In-Network Reimbursement Methodology	Establishes the factors used in provider and facility rate negotiations. These factors are considered in every negotiation without hierarchy and dependent upon the facts and circumstances presented in each negotiation.
Professional Fee Schedule: Controlled, Markets Standard and Provider Specific Policy	Set forth guidelines for the consistent application of in-network fee schedules across the provider network specific to M/S.

OPS 18: Policy and Procedure Maintenance, Review and Approval Process	The purpose of this policy is to ensure review and dissemination of policies and process within the scope of oversight by the Policy Committee in a timely manner.
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To the extent provider-specific reimbursement methodologies, fee schedule development principles, and reimbursement governance processes are addressed in HM-NET-010 and HM-NET-011, those documents are included as supporting documentation regarding reimbursement methodology administration and approval processes. These documents are cited solely for those purposes and not as determinants of MHPAEA benefit classification.

For purposes of compliance with MHPAEA's parity requirements Cigna classifies Mental Health/Substance Use Disorder (MH/SUD) and Medical/Surgical (M/S) benefits in accordance with generally recognized independent standards of current medical practice. The applicable benefit classifications are Inpatient, Outpatient, Prescription Drugs, and emergency care. Within the Outpatient Classification, Cigna uses the permitted subclassification of Office Visit and Outpatient - All Other. All Outpatient services (Office Visit and Outpatient - All Other) are provided in an outpatient setting such as a physician's office, free standing surgical or behavioral health outpatient facility.

- **Outpatient Office Visits** include routine evaluation and management, consultation, preventive, examination, and treatment services provided by a health care provider in an office setting. Cigna classifies these benefits as Outpatient Office Visits, as they are an evaluation, visit or consultation during which other services can be provided. Routine care is provided by a practitioner that offers a wide array of evaluation, assessment, and treatment services, as compared to specialized providers who offer a narrow scope of services, as confined by their licensure or the conditions under which they provide services.
- **Outpatient - All Other** include non-routine or specialized programs, items, services, and procedures provided in an office or outpatient setting. Non-routine care is specialized treatment and/or services provided by a practitioner within a narrow scope allowed by licensure or the conditions under which services may be provided in an office or facility setting. Services assigned to the "Outpatient All other" sub-classification include:
 - M/S Outpatient - All Other Services include lab, radiology, Outpatient surgery, Speech Therapy/Physical Therapy/Occupational Therapy, home health, Durable Medical Equipment, free standing surgical outpatient facility etc.
 - MH/SUD Outpatient All Other Services include Partial Hospitalization (PHP), Applied Behavior Analysis (ABA), Transcranial Magnetic Stimulation (TMS), free standing behavioral outpatient facility etc.

List of Services Subject to the NQTL:

The In-Network (INN) Outpatient Provider Reimbursement NQTL applies to the M/S and MH/SUD benefits listed below when furnished by participating facilities or practitioners and classified by the plan within the In-Network Outpatient benefit classification. The table identifies all benefits and services within the benefit classification to which the NQTL applies: The listed benefits are classified as M/S or MH/SUD in accordance with the plan terms and generally recognized independent standards of current medical practice. The reimbursement NQTL applies to the processes used to establish, negotiate, approve, and apply participating-provider reimbursement for each listed benefit or service.

	<i>Medical/Surgical</i>	<i>Mental Health & Substance Use</i>
Is NQTL applied to In-Network Outpatient-Office sub-classification?	Yes Primary Care Physician (PCP) Services/Office visit Specialty Care Physician Services/Office Visit Telehealth	Yes Office Visits, including Individual, Family and Group Psychotherapy and Medication Management Telehealth
Is NQTL applied to In-Network Outpatient-All Other sub-classification?	Yes Advanced Radiology Consumable Medical Supplies Convenience Care (Lab, Radiology, Surgery) Dialysis not performed in a dialysis center Durable Medical Equipment (DME) Home Health Care Hospice - OP Lab Services Outpatient Short Term Rehab Outpatient Chiro Outpatient Facility Services (surgical and non-surgical) Outpatient Non-Office Preventive (Facility) Outpatient Non-Office Preventive (Professional) Outpatient Professional Services (surgical and non-surgical) Radiology Services - OP Facility (surgical and non-surgical) Radiology - Physician's Services/Office Visit (PCP/SCP) Surgery Performed in the Physician's Office (PCP/SCP) Urgent Care Facility	Yes Partial Hospitalization Program Intensive Outpatient Services Applied Behavior Analysis Transcranial Magnetic Stimulation

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See [45 CFR 146.137\(c\)\(2\)](#). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

- (i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which

- MH or SUD and which medical/surgical benefits are subject to the NQTL; and
- (ii) A definition of each factor, including:
- (A) A detailed description of the factor;
 - (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
 - (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also [FAQ 45](#) guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Cigna utilizes **the factors outlined below** when applying the In-Network (INN) Outpatient Provider Reimbursement NQTL for the Outpatient – Office and Outpatient – All Other benefit classifications. In designing and applying the In-Network Outpatient Provider Reimbursement NQTL no additional factors were considered and rejected beyond what is set forth in the tables below. The same categories of factors are available for consideration in M/S and MH/SUD reimbursement determinations. The relevance and relative significance of an individual factor may vary based on the documented facts and circumstances of the provider, service, geographic market, reimbursement methodology, and negotiation. Cigna does not apply a predetermined weighting or decision standard that is more restrictive for MH/SUD providers or services than for comparable M/S providers or services.

Unless otherwise expressly stated, all information provided in Step 2 applies equally to the Base Rates, Final Rates, and Adjusted Rates described in this comparative analysis.

Benefit Classification/	Factors	Sources for Each Factor
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Sub-classification		
In-Network Outpatient - Office	1. Federal and State Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type and/or specialty (e.g., hospital, clinic, or practitioner) which determines reimbursement methodology. 3. Medicare Baseline Rates 4. Market Dynamics (including provider supply, network need, demand for provider type or specialty, network adequacy, reputation/name recognition, - perceived or actual: quality information, and bargaining power). 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive Insights, when available	1. Federal and State Law Where State/Federal law is not applicable, the following factors are also considered: 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology (i.e., hospital, clinic, and practitioner) and/or specialty (e.g., physician practitioners vs. non-physician practitioners vs. facilities). 3. Medicare Baseline Physician Fee Schedule (PFS), which uses Resource Based Relative Value Scale (RBRVS) systems 4. Internal analysis of market dynamics and network need/network adequacy including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Research related to reputation or name recognition amongst the community. Quality of Care/Service complaint reviews or status. Bargaining power (combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate) 5. Medicare Geographical Practice Cost Index ("GPCI"), which is a component of the Medicare PFS. i.e., market rate and payment type for provider type and/or specialty. 6. Types of Service are identified by CPT and HCPCS codes and internal Cigna data. 7. Internal determination (e.g., financial planning processes, medical cost forecasting analyses, actuarial projections, trend analysis, and annual budget planning review.) 8. Internal Cigna claims, utilization, reimbursement, and provider contracted data analyses. 9. Coordination of Benefit (COB) information from other carriers, Transparency in Coverage Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available.
In-Network Outpatient - All Other	1. Federal and State Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type and/or specialty (e.g., hospital, clinic, or	1. Federal and State Law Where State/Federal law is not applicable, the following factors are also considered: 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology (i.e., hospital, clinic, and practitioner) and/or specialty (e.g.,

	practitioner) which determines reimbursement methodology. 3. Medicare Baseline Rates 4. Market Dynamics (including provider supply, network need, demand for provider type or specialty, network adequacy, reputation/name recognition, - perceived or actual: quality information, and bargaining power). 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive Insights, when available	physician practitioners vs. non-physician practitioners vs. facilities). 3. Facility: Medicare Outpatient Prospective Payment System (OPPS) Practitioner: Medicare Baseline Physician Fee Schedule, which uses Resource Based Relative Value Scale (RBRVS) system. 4. Internal analysis of market dynamics and network need/network adequacy including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Research related to reputation or name recognition amongst the community. Quality of Care/Service complaint reviews or status. Bargaining power (combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate) 5. Facility: Hospital Wage Index to adjust payments based on geographic differences in hospital labor costs. Practitioner: Medicare Geographical Practice Cost Index ("GPCI"), which is a component of the Medicare PFS. i.e., market rate and payment type for provider type and/or specialty. 6. Types of Service are identified by CPT and HCPCS codes and internal Cigna data. 7. Internal determination (e.g., financial planning processes, medical cost forecasting analyses, actuarial projections, trend analysis, and annual budget planning review.) 8. Internal Cigna claims, utilization, reimbursement, and provider contracted data analyses. 9. Coordination of Benefit (COB) information from other carriers, Transparency in Coverage Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available
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In establishing the factors used to determine In-Network (INN) Outpatient Provider Reimbursement, Cigna considers the following sources and **evidentiary standards**:

Benefit Classification/Su b-classification	Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
In-Network Outpatient - Office	1. Federal and State Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type and/or specialty (e.g., hospital, clinic, or practitioner) which determines reimbursement methodology. 3. Medicare Baseline Rates 4. Market Dynamics (including provider supply, network need, demand for provider type or specialty, network adequacy, reputation/name recognition, - perceived or actual: quality information, and bargaining power). 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive Insights, when available	1. When a federal or state law, regulation, rate order, or other binding reimbursement requirement applies, the Plan applies the legally required methodology or rate. No discretionary threshold is applied. Where State/Federal law is not applicable, the following factors are also considered: 2. Provider type and/or specialty: The provider is assigned to the reimbursement methodology corresponding to the provider's applicable license, credential, specialty, scope of practice, billing designation, and facility or practitioner status. The threshold is whether the provider satisfies the documented classification requirements for the applicable reimbursement schedule. Provider type or specialty does not independently determine a negotiated rate outside the applicable reimbursement framework unless a documented network, market, service, or contracting consideration supports a different rate. 3. Resource-Based Relative Value Scale ("RBRVS"): Cigna utilizes the Medicare Pricing Tool to determine if the provider's (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale	1. Federal and State Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology. (i.e., hospital, clinic, and practitioner) and/or specialty (e.g., physician practitioners vs. non-physician practitioners vs. facilities). 3. Medicare Baseline Physician Fee Schedule , which uses Resource Based Relative Value Scale (RBRVS) system. 4. Internal analysis of market dynamics /network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Name Recognition/Reputation: customer/client requests, internet reviews/searches Quality: internet reviews/searches (actual and/or perceived), complaints. Bargaining Power (is a combination of provider supply, reputation/name recognition, and quality which may

		("RBRVS"), a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna's RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually: $[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice Expense RVU} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})] = \text{Geographically Adjusted RVU Total} \times \text{Conversion Factor (CF)} = \text{Cigna RBRVS geographically adjusted fee Reimbursement.}$ 4. Supply of provider type and/or specialty (network adequacy): Provider specific fee schedules are used for multi-specialty specialty groups or unique specialty groups where reimbursement terms must be customized to meet the needs of that group or specialty. Provider specific or specialty fee schedules are used to retain providers if the providers are needed to meet network access requirements and/or increase membership. Demand is established through documented claims or utilization history, referral activity, member or client requests, anticipated membership, service-area changes, or projected utilization. No single utilization level automatically determines the outcome unless a formally approved numerical standard applies. Reputation and Name Recognition is qualitative determination which may be established through	enhance a provider's and/or facility's ability to negotiate) 5. Medicare Geographical Practice Cost Index ("GPCI"), which is a component of the Medicare PFS. i.e., market rate and payment type for provider type and/or specialty. Medicare Geographical Practice Cost Index ("GPCI"), i.e., market rate and payment type for provider type and/or specialty components of Relative Value Units (RVU's), geographic practice cost indices (GPCI's), conversion factor, and base relativity factors, as defined by Cigna. 6. Type of Service are identified by CPT and HCPCS codes and internal Cigna data 7. Internal determination (e.g., financial planning processes, medical cost forecasting analyses, actuarial projections, trend analysis, and annual budget planning review.) 8. Internal Cigna claims utilization, reimbursement, and provider contracted data analyses. 9. Coordination of Benefit (COB) information from other carriers, Transparency in Coverage Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII
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		documented member requests, referral patterns, recognized specialty programs, market research, accreditation, or other reliable market information. Customer reviews alone are not determinative. Quality is determined by qualitative assessment of quality of care and/or quality of service. Quality of Care Complaints (QOC): A complaint (including written or verbal expression of dissatisfaction) received from the Customer or the Customer's representative, including quality of care concerns that has or has potential to negatively impact the Customer's clinical outcome. An example may be one of the following: • Appropriateness of Care - alleging mismanagement of care, conflicting diagnoses, improper treatment or exam, unnecessary treatment, wrong treatment, unclear treatment, refusal of care caused complications leading to additional service or care. • Continuity of Care - appropriateness of care resulting in a disruption in treatment. Individual in need of assistance in obtaining appropriate treatment from another healthcare professional/facility, business partner, or healthcare process. The primary issue is the need to obtain the appropriate care.	Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available.
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		• Refusal of Care - denial of care by a healthcare professional or provider for such reasons as no identification card, late for appointment, healthcare professional missing scheduled appointment, or no healthcare professional available. Quality of Service Complaint: An expression of dissatisfaction regarding the healthcare delivery process. An example may be one of the following: • Accessibility of Service - dissatisfaction about availability of care (i.e., too long to get appointment, healthcare professional never available, too long in office for scheduled appointments, individual does not feel they were given sufficient time during their visit). • Attitude of Practitioner/healthcare professional - dissatisfaction about attitude of a healthcare professional or their office staff, such as uncaring, rude, short-tempered, or threatening, which may include issues of professionals not communicating test results. • Availability of Service - dissatisfaction about availability of providers in a geographical area to meet the Customer's care needs (i.e., too few healthcare professionals resulting in timely scheduling problems in an area, drive is too far,	
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		healthcare professional not accepting new patients). This would include provider not available after hours. • Facility Environment - dissatisfaction about healthcare professional's office environment (i.e., unclean, too few chairs, no parking.) • Uneducated Healthcare Practitioner/Practitioner Staff - dissatisfaction about business partner's staff being unaware of procedures to follow to access care. • Healthcare process - dissatisfaction with elements of the healthcare process, attitude/behavior of the Healthcare staff. • Bargaining Power is a qualitative combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate. A single complaint does not independently establish a quality concern or reimbursement consequence. Consideration is based on substantiation, severity, frequency, recency, corrective action status, and other available quality information. 5. Geographic market (i.e., market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon Geographic Practice Cost Index ("GPCI"). GPCI reflects the relative cost	
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		of practicing in a locality against a national average. Each relative value is multiplied by the corresponding GPCI. The three component factors are then accumulated to arrive at an adjusted amount. This amount is then multiplied by the conversion factor to establish the Medicare full fee schedule amount in the Medicare Physician Fee Schedule Database (MPFSDB). CMS performs calculations on the fee schedule, with the exception of carrier-priced procedure codes, and provides fee schedule calculations to the Medicare Administrative Contractors (MACs) 6. The scope and type of services are established using the applicable CPT, HCPCS, revenue, DRG, APC, ASC, diagnosis, place-of-service, bill-type, provider-specialty, and other relevant coding or service information. The applicable reimbursement methodology is selected based on whether the service is facility or practitioner, inpatient, or outpatient, professional or institutional, and otherwise subject to the relevant payment methodology. The threshold is whether the service and claim attributes satisfy the documented coding and reimbursement requirements for the applicable fee schedule or payment arrangement. 7. Medical cost budget: The evidentiary standard is the approved annual medical-cost budget and the projected financial effect of the proposed reimbursement arrangement. The factor is	
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		established when the projected cost of the proposal is within or outside the available budgetary authority for the applicable market, provider type, service, or contracting initiative. Although there is no universal numerical threshold applicable to every provider negotiation, the assessment must be supported by a documented financial analysis and the applicable approval authority. A proposal outside the initial budget does not automatically preclude contracting but may require additional review, alternative contract terms, or higher-level approval. 8. Utilization: Claims and utilization history may be considered as evidence of member demand, referral patterns, service use, continuity-of-care needs, or potential network need. Prior utilization supports the existence of demand but is not required to establish network need. Absence of prior utilization is not, by itself, determinative and is evaluated together with network adequacy, provider availability, anticipated membership, geographic access, specialty needs, and other relevant evidence. 9. Competitive insights: May be considered when sufficiently reliable and comparable information is available for the same or similar service, provider type, specialty, geographic area, and payment methodology. Competitive information does not automatically establish a required rate. It informs the assessment of whether	
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		proposed reimbursement is reasonably consistent with available market information. Differences in coding, provider type, contract structure, geography, service mix, and data period are considered when evaluating comparability.	
In-Network Outpatient - All Other	1. Federal and State Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type and/or specialty (e.g., hospital, clinic, or practitioner) which determines reimbursement methodology. 3. Medicare Baseline Rates 4. Market Dynamics (including provider supply, network need, demand for provider type or specialty, network adequacy, reputation/name recognition, - perceived or actual: quality information, and bargaining power). 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive Insights, when available	1. Federal and State Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider type and/or specialty: The provider is assigned to the reimbursement methodology corresponding to the provider's applicable license, credential, specialty, scope of practice, billing designation, and facility or practitioner status. The threshold is whether the provider satisfies the documented classification requirements for the applicable reimbursement schedule. Provider type or specialty does not independently determine a negotiated rate outside the applicable reimbursement framework unless a documented network, market, service, or contracting consideration supports a different rate. 3. Facility: Medicare baseline rates: Ambulatory Surgical Centers (ASCs) for facility-based services provided during outpatient surgical procedures is a value-based, prospective payment system that determines how much an ASC is paid for each covered procedure, regardless of the actual cost incurred.	1. Federal and State Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology. (i.e., hospital, clinic, and practitioner) and/or specialty (e.g., physician practitioners v. non-physician practitioner v. facility). 3. Facility: Medicare Outpatient Prospective Payment System (OPPS) Practitioner: Medicare Baseline Physician Fee Schedule, which uses Resource Based Relative Value Scale (RBRVS) system. 4. Internal analysis of market dynamics /network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Name Recognition/Reputation: customer/client

		Ambulatory Payment Classifications ("APC"). APC groups outpatient services that are clinically similar and use comparable resources. Each group is assigned a fixed payment rate. Services are reported using HCPCS/CPT codes and are assigned an APC group. Medicare's calculation is APC relative weight x OPPS conversion factor. Adjustments are then made for geographic location and other factors. Percent of Charge – percent of covered billed charges. Per Diem – a per day, all-inclusive reimbursement rate for all covered services provided on that day. Practitioner: Resource-Based Relative Value Scale ("RBRVS"): Cigna utilizes the Medicare Pricing Tool to determine if the provider's (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale ("RBRVS"), a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna's RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually: $.[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice Expense RVU} \times \text{Practice Expense GPCI}) +$	requests, internet reviews/searches Quality: internet reviews/searches (actual and/or perceived), complaints. Bargaining Power (is a combination of provider supply, reputation/name recognition, and quality which may enhance a provider's and/or facility's ability to negotiate) 5. Facility: Hospital Wage Index to adjust payments based on geographic differences in hospital labor costs Practitioner: Medicare Geographical Practice Cost Index ("GPCI"), which is a component of the Medicare PFS. i.e., market rate and payment type for provider type and/or specialty. 6. Type of Service are identified by CPT and HCPCS codes and internal Cigna data. 7. Internal determination (e.g., financial planning processes, medical cost forecasting analyses, actuarial projections, trend analysis, and annual budget planning review.) 8. Internal Cigna claims utilization, reimbursement and provider contracting data analyses. 9. Coordination of Benefit (COB) information from other carriers, Transparency in
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		(Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically adjusted fee Reimbursement. 4. Supply of provider type and/or specialty (network adequacy): Provider specific fee schedules are used for multi-specialty specialty groups or unique specialty groups where reimbursement terms must be customized to meet the needs of that group or specialty. Provider specific or specialty fee schedules are used to retain providers if the providers are needed to meet network access requirements and/or increase membership. Demand is established through documented claims or utilization history, referral activity, member or client requests, anticipated membership, service-area changes, or projected utilization. No single utilization level automatically determines the outcome unless a formally approved numerical standard applies. Reputation and Name Recognition is a qualitative determination which may be established through documented member requests, referral patterns, recognized specialty programs, market research, accreditation, or other reliable market information. Customer reviews alone are not determinative. Quality of Care Complaints (QOC): A complaint (including written or verbal expression of dissatisfaction) received from the Customer or the Customer's representative,	Coverage Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available
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		including quality of care concerns that has or has potential to negatively impact the Customer's clinical outcome. An example may be one of the following: • Appropriateness of Care - alleging mismanagement of care, conflicting diagnoses, improper treatment or exam, unnecessary treatment, wrong treatment, unclear treatment, refusal of care caused complications leading to additional service or care. • Continuity of Care - appropriateness of care resulting in a disruption in treatment. Individual in need of assistance in obtaining appropriate treatment from another healthcare professional/facility, business partner, or healthcare process. The primary issue is the need to obtain the appropriate care. • Refusal of Care - denial of care by a healthcare professional or provider for such reasons as no identification card, late for appointment, healthcare professional missing scheduled appointment, or no healthcare professional available. • Quality of Service Complaint: An expression of dissatisfaction regarding the healthcare delivery process. An example may be one of the following:	
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		• Accessibility of Service - dissatisfaction about availability of care (i.e., too long to get appointment, healthcare professional never available, too long in office for scheduled appointments, individual does not feel they were given sufficient time during their visit). • Attitude of Practitioner/healthcare professional - dissatisfaction about attitude of a healthcare professional or their office staff, such as uncaring, rude, short-tempered, or threatening, which may include issues of professionals not communicating test results. • Availability of Service - dissatisfaction about availability of providers in a geographical area to meet the Customer's care needs (i.e., too few healthcare professionals resulting in timely scheduling problems in an area, drive is too far, healthcare professional not accepting new patients). This would include provider not available after hours. • Facility Environment - dissatisfaction about healthcare professional's office environment (i.e., unclean, too few chairs, no parking.) • Uneducated Healthcare Practitioner/Practitioner Staff - dissatisfaction about business partner's staff being unaware of	
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		procedures to follow to access care. • Healthcare process - dissatisfaction with elements of the healthcare process, attitude/behavior of the Healthcare staff. • Bargaining Power is a qualitative combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate. No single bargaining power consideration is determinative. Bargaining power is evaluated based on provider supply, network need, replacement availability, quality, market presence, referral patterns, and other documented contracting considerations. A single complaint does not independently establish a quality concern or reimbursement consequence. Consideration is based on substantiation, severity, frequency, recency, corrective action status, and other available quality information. 5. Geographic market (i.e., market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon Geographic Practice Cost Index ("GPCI"). GPCI reflects the relative cost of practicing in a locality against a national average. Each relative value is	
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		multiplied by the corresponding GPCI. The three component factors are then accumulated to arrive at an adjusted amount. This amount is then multiplied by the conversion factor to establish the Medicare full fee schedule amount in the Medicare Physician Fee Schedule Database (MPFSDB). CMS performs calculations on the fee schedule, with the exception of carrier-priced procedure codes, and provides fee schedule calculations to the Medicare Administrative Contractors (MACs) 6. The scope and type of services are established using the applicable CPT, HCPCS, revenue, DRG, APC, ASC diagnosis, place-of-service, bill-type, provider-specialty, and other relevant coding or service information. The applicable reimbursement methodology is selected based on whether the service is facility or practitioner, inpatient, or outpatient, professional or institutional, and otherwise subject to the relevant payment methodology. The threshold is whether the service and claim attributes satisfy the documented coding and reimbursement requirements for the applicable fee schedule or payment arrangement. 7. Medical cost budget: The evidentiary standard is the approved annual medical-cost budget and the projected financial effect of the proposed reimbursement arrangement. The factor is established when the projected cost of the	
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		proposal is within or outside the available budgetary authority for the applicable market, provider type, service, or contracting initiative. Although there is no universal numerical threshold applicable to every provider negotiation, the assessment must be supported by a documented financial analysis and the applicable approval authority. A proposal outside the initial budget does not automatically preclude contracting but may require additional review, alternative contract terms, or higher-level approval. 8. Utilization: Claims and utilization history may be considered as evidence of member demand, referral patterns, service use, continuity-of-care needs, or potential network need. Prior utilization supports the existence of demand but is not required to establish network need. Absence of prior utilization is not, by itself, determinative and is evaluated together with network adequacy, provider availability, anticipated membership, geographic access, specialty needs, and other relevant evidence. 9. Competitive Insights: May be considered when sufficiently reliable and comparable information is available for the same or similar service, provider type, specialty, geographic area, and payment methodology.	
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		Competitive information does not automatically establish a required rate. It informs the assessment of whether proposed reimbursement is reasonably consistent with available market information. Differences in coding, provider type, contract structure, geography, service mix, and data period are considered when evaluating comparability.	
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Except where applicable law or the selected reimbursement methodology requires a particular result, the identified factors do not operate as fixed eligibility criteria and are not assigned predetermined numerical weights. Provider type, billing status, service type, and geographic location are considered first to identify the applicable reimbursement framework and benchmark. Contracting personnel then evaluate provider supply, network need, demand, access considerations, quality information, bargaining position, utilization, competitive information, and medical-cost impact based on the documented facts of the negotiation. The relative significance of these factors may vary, but the same categories of factors are available for consideration for M/S and MH/SUD providers.

Cigna uses objective, reliable, and verifiable information in designing and applying the In-Network Outpatient Reimbursement NQTL. To control for bias, Cigna evaluates provider reimbursement using multiple independent and relevant sources and does not base a determination exclusively on a single source. Cigna reviews internal claims experience, utilization analyses, transparency data, provider directories, licensing sources, market information, and other external sources collectively and validates the information for reasonableness, reliability, completeness, and comparability before relying upon it. Cigna supplements or excludes information that is incomplete, inconsistent, outdated, or otherwise unreliable. Cigna considers competitive information only after confirming comparability based on provider type, service type, geographic market, reimbursement methodology, and data period.

Step 3: Description of how factors are used in the design and application of the NQTL.

See [45 CFR 146.137\(c\)\(3\)](#). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

- (1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;
- (2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon

- in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;
- (3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;
 - (4) If more than one factor is identified and defined in Step 2, an explanation of:
 - (A) How all of the factors relate to each other;
 - (B) The order in which all of the factors are applied, including when they are applied;
 - (C) Whether and how any factors are given more weight than others; and
 - (D) The reasons for the ordering or weighting of the factors.
 - (5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also [FAQ 45](#) guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Design and Application:

Cigna considers contracting requests from both MH/SUD and M/S providers/facilities. Cigna does not limit parties with whom it will contract and negotiate rates. Participation in Cigna's M/S and/or MH/SUD network is subject to the provider's satisfaction of applicable credentialing, licensure, contracting, reimbursement, and network requirements applicable to the provider's type, specialty, scope of practice and facility or practitioner status. Although underlying requirements may differ by provider type, Cigna does not impose an MH/SUD-specific contracting or reimbursement requirement that is more stringent than the requirement applied to comparable M/S providers.

Both MH/SUD and M/S provider contract negotiations are assessed based on the provider-specific facts and information available at the time of negotiation. Contract reimbursement negotiations consider market and provider-specific factors including, provider's size and scope, the availability or scarcity of comparable providers, network need, geographic access considerations, specialty demand, reputation or name recognition, quality information, and other market dynamics. These considerations collectively inform the provider's negotiating position and may affect the extent to which standard reimbursement terms are accepted, modified, or subject to further negotiation. As a result, different providers and facilities may have variability in negotiation outcomes depending on the availability of alternative providers, the services offered, and the degree to which the provider is needed to support access, adequacy, or market competitiveness. These factors are evaluated for both M/S and MH/SUD providers and facilities using the same overall contracting framework.

While the same core factors are considered across M/S and MH/SUD services within the In-Network Outpatient—Office and In-Network Outpatient—All Other benefit classifications, there are operational nuances in how those factors are applied depending on whether the reimbursement determination involves practitioner services or facility services, including differences in the applicable benchmarks, payment methodologies, and service-specific data sources. Any differences described in the applicable benchmarks, reimbursement methodologies, or data sources are not differences between MH/SUD and M/S services within the same benefit classification; rather, they reflect the operational distinction between practitioner reimbursement and facility reimbursement, and that distinction is applied consistently to both MH/SUD and M/S services.

For practitioner services within the outpatient office and outpatient - all other benefit classification, standard rates for in-network M/S and MH/SUD outpatient services are determined as follows:

- CMS (Medicare) RVU (relative value units);
- Ingenix data derived from practitioner charges, where available, may be used as a benchmark for procedure codes that do not have Medicare rates or RVUs;
- Clinical Lab and Pathology codes, where applicable;
- Place of Service (POS) (e.g., office, facility);
- Geographic market, which may be adjusted based upon the Medicare Geographical Practice Cost Index (GPCI).

Cigna applies this methodology to determine Standard Reimbursement Rates for both M/S and MH/SUD services. Cigna RBRVS is set annually:

$$\frac{[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice RVU} \times \text{Practice GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})]}{\text{x Conversion Factor}} = \text{Reimbursement}$$

The same reimbursement sources are applied to both M/S and MH/SUD services. When Medicare RVUs are unavailable, alternative reimbursement data sources and market-based information are used consistently across both benefit types.

For both M/S and MH/SUD services where an applicable CMS rate, RVU, or other approved benchmark is unavailable, the final rate for a service covered by the contract is determined to be:

- billed charges for the service;
- negotiated discount off of billed charges for the service during the contracting process

There are no facility services reflected within the In-Network Outpatient—Office benefit classification because office visits are, by definition, professional services furnished by a practitioner in an office setting; when outpatient services are furnished by a facility or billed on an institutional/facility basis, they are classified under In-Network Outpatient—All Other rather than Outpatient—Office. For facility services within the outpatient - all other benefit classification, reimbursement methodologies utilize Medicare Outpatient Prospective Payment System (“OPPS”) as a benchmark and rely upon:

- Ambulatory Payment classifications (APCs) to group services based on clinical and resource similarity.
- Ambulatory Surgical Center (ASC) for the facility-based services provided for outpatient surgical procedures.
- Outlier payments⁴ for services that are unusually expensive.

Reimbursement rates are analyzed and negotiated by a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The personnel identified below are the contracting, rate-setting, review, and approval personnel involved in evaluating and implementing provider reimbursement rates for M/S and MH/SUD services.

- Behavioral Health Contracting Director: Master’s Degree preferred. 6+ years of experience. Healthcare M/S Bachelor’s Degree; MBA or Master’s Degree in HealthCare Administration or health-related field preferred; minimum of 10 years managed healthcare experience preferred.
- Behavioral Health Contract Negotiators: Bachelor’s Degree or 3-5 years’ experience in provider services/relations/contracting/network development.
- Healthcare M/S Bachelor’s Degree or higher preferred; 3-7 years’ experience preferred (due to various levels of contractor roles).

Base Rates:

Standard reimbursement rates are reimbursement rates that a provider accepts without contract negotiation. Standard reimbursement rates for M/S and MH/SUD outpatient services are set based upon standard fee schedules. All of which are developed for facilities, physicians and non-physicians by state or region. Cigna uses its standard in-network reimbursement methodology for M/S and MH/SUD providers and facilities for initial negotiation when a provider enters the network and for the renegotiation of continued network participation.

⁴ As defined by CMS, outlier payments are provided on a service basis when the cost of a service exceeds the APC payment amount multiplier threshold (the APC payment amount multiplied by a certain amount) as well as the APC payment amount plus a fixed-dollar amount threshold (the APC payment plus a certain dollar amount)

Adjusted Rates:

Non-Standard reimbursement rates are fee schedules developed based upon a negotiation request. The following factors are considered in all negotiations for both M/S and MH/SUD Non-Standard reimbursement:

- Federal or State Law, as applicable

Where State/Federal law is not applicable, the following factors are also considered:

- Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty which determines the applicable type of reimbursement.
- Medicare Baseline Rates
- Market Dynamics (applied equally to M/S and MH/SUD providers and facilities), including supply of provider type and/or specialty, network need and demand, network adequacy considerations, provider reputation, name recognition, quality indicators, provider-specific market position, and bargaining power.
- Geographic Market
- Scope and Type of services
- Medical Cost Budget
- Utilization
- Competitive insights, when available

The same methodologies are used for both M/S and MH/SUD rate negotiation and any requested negotiation from standard reimbursement rates must be supported by documented financial analysis and the appropriate approval workflows in the respective contracting areas, as set forth herein. All staff participating in contract negotiation are trained on internal Cigna policies and procedures and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests and escalate for justification and approval of any deviations. If a provider or facility declines the standard reimbursement rate, Cigna may engage in rate negotiation using the applicable standard rate as the starting point. The request is reviewed by contracting personnel under the same framework used for both M/S and MH/SUD providers, considering factors such as provider type, specialty, service scope, geographic market, utilization, network need, market dynamics, competitive information when available, and medical cost budget impact. Following that review, Cigna may decline further negotiation, issue a counteroffer, or accept the proposed rate, subject to applicable documentation and approval requirements. If counteroffers are exchanged, negotiations may continue until the parties reach agreement or either party elects not to proceed.

The specific benchmark or payment methodology may differ depending on whether the services are practitioner or facility services, but the negotiation process, decision-making factors, documentation expectations, and approval controls are aligned for M/S and MH/SUD. Accordingly, non-standard reimbursement requests are not evaluated under a more stringent framework for MH/SUD than for M/S.

Rate negotiation requests may be initiated by the provider/facility or Cigna/Evernorth for both MH/SUD and M/S networks. Most often, the provider/facility initiates. The Provider/Facility would outreach to Cigna/Evernorth indicating the desire for a higher initial rate offering or requesting to renegotiate existing rates. Internal review of the request and assessment of the factors, sources

and thresholds as listed above is conducted by MH/SUD or M/S contracting negotiator staff. A determination is made based on that assessment and communicated to the provider/facility:

- Decline to engage in renegotiation (no counter offer)
- Counteroffer provider/facility's proposal
- Agree to provider/facility's proposal.

In the event of a counteroffer, the provider/facility may decline, accept, or provide an additional counteroffer. In the event of a secondary counter offer, the process could continue to repeat until such time that either party declines to continue negotiations or an agreement is reached.

Re-negotiations of reimbursement rates are conducted according to the terms of the contract, or if not specified in the contract, they are conducted at the request of either party.

Provider volume does not mechanically determine the initial standard fee schedule offered to an individual provider. However, provider supply, network need, projected membership, geographic access, and specialty availability may be considered when evaluating whether a non-standard reimbursement arrangement is warranted.

The negotiation strategy, counteroffer methodology, and final reimbursement determination are based on the documented evaluation of the factors, evidentiary standards, sources, and approval workflows described throughout this analysis. No single factor is independently determinative unless required by applicable law or reimbursement methodology. Final reimbursement determinations are subject to the applicable approval workflow and authority levels and are made using comparable processes and standards for both M/S and MH/SUD providers and facilities.

Final Rates:

Upon execution of the provider agreement, the applicable Base Rate or Adjusted Rate accepted by the facility or practitioner becomes the Final Rate and is incorporated into the provider's contracted fee schedule. This process is applied under the same contracting framework to both M/S and MH/SUD facilities and practitioners.

Step 4: Demonstration of comparability and stringency as written.

See [45 CFR 146.137\(c\)\(4\)](#). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

- (1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;
 - (A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and

medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

- (B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;
- (2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;
- (3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and
- (4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [\[Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits\]](#):
- (A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;
- (B) In the design of the factors or evidentiary standards; or
- (C) In the application or design of the NQTL.

See also [FAQ 45](#) guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [\[Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review\]](#).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

As Written:

Although practitioner type, licensure, specialty, scope of practice and billing designation may determine the applicable reimbursement methodology or fee schedule, Cigna does not impose an across-the-board reimbursement reduction because a practitioner is classified as a non-physician practitioner.

Cigna does not delegate to third-party vendors the responsibility for establishing, negotiating, or approving, reimbursement rates for in-network outpatient facilities or practitioners..

To promote consistent application of the Provider Reimbursement NQTL, Cigna reviews the relevant policies and procedures at least annually and more frequently when required by legal, regulatory, business, or operational changes. The review evaluates whether the written M/S and MH/SUD processes remain consistent with applicable requirements and whether identified differences affect the comparability or relative stringency of the NQTL. Cigna is providing the below Provider Reimbursement policies relevant to the design and application of the Provider Reimbursement NQTL as evidence of its governance process and consistent administration of the NQTL.. As described in policy *OPS-18 Policy and Procedure Maintenance, Review and Approval Process*, these Cigna policies were developed, reviewed and approved in accordance with applicable regulatory requirements and relevant to URAC and NCQA standards.

Base Rates:

The In-Network Reimbursement Methodology Document applicable to both M/S and MH/SUD outlines each factor as described in Step 2 that is used to determine reimbursement.

The In-Network Reimbursement Methodology document applies the same categories of factors to both MH/SUD and M/S reimbursement determinations, including Federal and State Law, Provider Type, Medicare Baseline Rates, Market Dynamics, Geographic Market, Scope and Type of Service, Medical Cost Budget, Utilization, and Competitive Insights. As written, these factors are available for consideration in both MH/SUD and M/S reimbursement determinations and are not subject to a separate or more restrictive set of factors for MH/SUD providers.

The *Controlled, Markets Standard and Provider Specific Policy (Article: 000126481)* describes the standard fee schedule applicable to M/S providers, and the *Provider Fee Schedules Policy (HM-NET-011)* and *Fee Exceptions Policy (HM-NET-010)* which describes the standard fee schedule applicable to MH/SUD providers. The table set forth below describes the comparability of the application of the NQTL in writing:

M/S Policy Professional Fee Schedule: Controlled, Markets Standard and Provider Specific Policy	MH/SUD Policy Provider Fee Schedules Policy (HM-NET-011) & Fee Exceptions Policy (HM-NET-010)
Cigna Controlled (CC) The fee schedule is established by geography, usually at a market or regional level.	Standard Fee Schedules: Fee schedules developed for each provider type by state, or sometimes by region, that reflect the geographic variations in pricing in that state or region. Standard fee schedules are developed using the Centers for Medicare and Medicaid Services (CMS) Medicare allowable rate as a benchmark. Resource-Based Relative Value Scale (RBRVS) is the basis for determining Medicare’s allowable rates for services.

As noted in the table above, Standard fee schedules for M/S and MH/SUD are determined by the Medicare allowable rate as a benchmark (RBRVS). Although the M/S and MH/SUD policies use different terminology, both establish standard fee schedules based on regional or market conditions and utilize approval processes designed to support appropriate network access and financial oversight.

The M/S Cigna-controlled fee schedule is an administrative fee schedule maintained by Cigna and may be updated periodically in accordance with applicable provider agreements. Because reimbursement values may be modified by Cigna over time, it does not represent a negotiated provider-specific reimbursement arrangement. By contrast, MH/SUD providers are reimbursed through either standard fee schedules established through the contracting process, which provide agreed-upon reimbursement terms between the parties. Accordingly, the existence of a Cigna-controlled fee schedule for certain M/S arrangements does not create a less stringent reimbursement methodology for M/S providers or a more stringent methodology for MH/SUD providers. The absence of a Cigna-controlled schedule within the MH/SUD contracting model reflects a different administrative structure and does not limit the ability of MH/SUD providers to negotiate non-standard reimbursement rates.

As written, the M/S and MH/SUD reimbursement policies use different terminology and reflect different administrative structures. For example, the M/S policy references “Cigna-Controlled Fee Schedules”, whereas the MH/SUD policy references “Standard Fee Schedules.” These differences do not by themselves establish a difference in substantive standards applied to M/S and MH/SUD reimbursement. Both policies identify and comparable categories of considerations for establishing reimbursement arrangements, including Medicare-derived benchmarks, regional or market considerations, provider type, and applicable reimbursement methodology. Both policies also permit arrangements that depart from the otherwise standard fee schedule and provide for approval processes designed to address network access and financial oversight.

The written policies do not require MH/SUD providers to satisfy reimbursement criteria, documentation requirements, approval levels, network need thresholds, or quality standards that are more restrictive than those applicable or available for consideration with respect to M/S providers. Although the policies differ in terminology and administrative structure, the identified differences do not impose additional conditions or restrictions on MH/SUD providers. Accordingly, based on the terms of the written policies, the processes, strategies, evidentiary standards, and

other factors used to design and apply the Provider Reimbursement NQTL are comparable to and applied no more stringently to MH/SUD benefits than to M/S benefits within the applicable outpatient classifications.

Facility reimbursement Methodologies. For participating outpatient facilities, the selection of a reimbursement methodology- such as diagnosis related group, per diem, or percent of covered charges- is based on relevant provider and services characteristics, including facility type, services furnished, contractual arrangement, and applicable reimbursement methodology applicable to those services. The methodology is not selected based on whether the facility furnishes MH/SUD or M/S services. As reflected in the written policies, comparable factors, evidentiary standards, negotiation processes and approval requirements govern the selection and application of facility reimbursement methodologies for MH/SUD and M/S providers.

Provider Administrative Guidance. Cigna also maintains publicly available reference guides to in-network practitioners and facilities: the *Cigna Health Care Provider Reference Guide* for M/S providers and the *Evernorth Administrative Guidelines* for MH/SUD providers.

These materials do not establish reimbursement rates, select reimbursement methodologies, or prescribe approval standards. Instead, they provide administrative guidance concerning network participation and related operational processes. Cigna reviews these materials at least annually to identify material differences in the written administrative requirements applicable to M/S and MH/SUD providers. This review provides additional evidence that the administrative processes supporting implementation of the Provider Reimbursement NQTL are comparable and are not more stringent, as written, for MH/SUD providers than for M/S providers.

Adjusted Rates:

The In-Network Reimbursement Methodology Document applicable to both M/S and MH/SUD outlines each factor as described in Step 2 that is used to determine reimbursement.

The *Controlled, Markets Standard and Provider Specific Policy (Article: 000126481)* describes the standard fee schedule and exception policy applicable to M/S providers, and the *Provider Fee Schedules Policy (HM-NET-011)* and *Fee Exceptions Policy (HM-NET-010)* which describes the standard fee schedule and exceptions policy applicable to MH/SUD providers. The table set forth below describes the comparability of the application of the NQTL in writing:

M/S Policy Professional Fee Schedule: Controlled, Markets Standard and Provider Specific Policy	MH/SUD Policy Provider Fee Schedules Policy (HM-NET-011) & Fee Exceptions Policy (HM-NET-010)
Cigna uses three types of fee schedules: Cigna Controlled (CC) The fee schedules are established by geography, usually at a market or regional level.	Standard Fee Schedules: Fee schedules developed for each provider type by state, or sometimes by region, that reflect the geographic variations in pricing in that state or region.
Market Standard (MS) The rate exhibit for these schedules will define the reimbursement terms by service category and contain more detailed information than a Cigna Controlled fee schedule rate exhibit. Markets will typically create several market standard schedules at various resource-based relative value scale (RBRVS)	Standard fee schedules are developed using the Centers for Medicare and Medicaid Services (CMS) Medicare allowable rate as a benchmark. Resource-Based Relative Value Scale (RBRVS) is the basis for determining Medicare's allowable rates for services.

reimbursement levels to meet varying needs of the local network.	
Provider Specific (PS) Provider Specific schedules are viable alternatives based upon the characteristics and needs of the local provider community. Limited to the largest practitioner groups who decline to accept reimbursement using a Cigna Controlled or Market Standard fee schedule. Used to retain providers if the providers are needed to meet network access requirements and/or increase membership. Schedules may be set using a fixed year of Cigna RBRVS.	Behavioral Health will grant exceptions to the established outpatient clinic and practitioner fee schedules when required to contract with or retain practitioners who are essential to the integrity of the Practitioner network. These exception fee schedules will be established at a level that is supported by the Behavioral Health medical cost budget and will have the necessary Level of Authority approvals.

As noted in the table above, M/S and MH/SUD create fee schedules based on market/region. Standard fee schedules for M/S and MH/SUD are determined by the Medicare allowable rate as a benchmark (RBRVS). Both M/S and MH/SUD policies allow for exceptions to the standard fee, established rate by way of negotiation reflected as “Provider Specific for M/S providers and “exceptions” in the MH/SUD network. Although the M/S and MH/SUD policies use different terminology, both establish standard fee schedules based on regional or market conditions, permit provider-specific reimbursement exceptions, require justification for non-standard reimbursement arrangements, and utilize approval processes designed to support appropriate network access and financial oversight. As a point of reference, the number of fee schedules differ due to administrative and contracting structure, not because MH/SUD providers are subject to a more stringent reimbursement methodology. Both M/S and MH/SUD providers may obtain customized reimbursement arrangements through negotiation when standard fee schedules are not acceptable. The processes for evaluating, approving, and implementing non-standard reimbursement arrangements are comparable.

The M/S "market standard" and "provider-specific" fee schedules are administrative mechanisms used to implement negotiated reimbursement arrangements after a provider declines the standard fee schedule. Similarly, MH/SUD providers that decline the standard fee schedule may request and negotiate non-standard reimbursement arrangements through the fee exception process. In both cases, providers may obtain reimbursement rates that differ from the standard fee schedule through comparable contracting and negotiation process, using comparable factors, evidentiary standards, approval requirements, and escalation procedures.

The M/S Cigna-controlled fee schedule is an administrative fee schedule maintained by Cigna and may be updated periodically in accordance with applicable provider agreements. Because reimbursement values may be modified by Cigna over time, it does not represent a negotiated provider-specific reimbursement arrangement. By contrast, MH/SUD providers are generally reimbursed through either standard fee schedules or negotiated reimbursement arrangements established through the contracting process, which provide agreed-upon reimbursement terms between the parties. Accordingly, the existence of a Cigna-controlled fee schedule for certain M/S arrangements does not create a less stringent reimbursement methodology for M/S providers or a

more stringent methodology for MH/SUD providers. The absence of a Cigna-controlled schedule within the MH/SUD contracting model reflects a different administrative structure and does not limit the ability of MH/SUD providers to negotiate non-standard reimbursement rates.

For both M/S and MH/SUD providers, reimbursement negotiations begin with a standard fee schedule and may result in customized reimbursement terms when supported by negotiation and business need. The M/S market-standard and provider-specific fee schedules function as implementation mechanisms for negotiated reimbursement arrangements, while MH/SUD negotiated reimbursement is implemented through a fee exception process. These mechanisms achieve the same operational outcome—a negotiated reimbursement rate differing from the standard fee schedule—and are evaluated using the same contracting factors, governance standards, approval processes, and negotiation methodology. Accordingly, the processes and evidentiary standards used to establish reimbursement rates are comparable for M/S and MH/SUD providers.

As written, the M/S policy implements negotiated reimbursement arrangements through Market Standard and Provider-Specific fee schedules, while the MH/SUD policy implements negotiated reimbursement arrangements through a fee exception process. Although the implementation mechanisms and terminology differ, both reimbursement models allow providers to request reimbursement terms that differ from the standard fee schedule and both require consideration of comparable factors, evidentiary standards, approval requirements, and financial review processes. The identified differences reflect variations in administrative and contracting structure rather than differences in reimbursement stringency. Accordingly, MH/SUD providers are not subject to additional documentation requirements, approval thresholds, reimbursement criteria, or negotiation restrictions that are not similarly applicable to M/S providers.

For facility reimbursement, differences in the reimbursement methodology selected (e.g., DRG, Per Diem, or Percent-of-Charge) reflect provider type, services furnished, contractual arrangement, and applicable reimbursement methodology rather than whether the provider furnishes MH/SUD or M/S services. As written, the underlying factors, evidentiary standards, approval requirements, and negotiation processes applicable to these facility reimbursement methodologies are comparable for MH/SUD and M/S providers.

For both M/S and MH/SUD network providers, Cigna provides reference guides to in-network practitioners and facilities for guidance on administrative processes. The guides are delineated by MH/SUD (Evernorth Administrative Guidelines) and M/S (Cigna Health Care Reference Guide) and are publicly available on Cigna.com to any provider.

As additional evidence of administrative comparability, Cigna maintains provider reference materials for both M/S and MH/SUD providers. Although these documents do not establish reimbursement rates or reimbursement methodologies, they provide substantially similar administrative guidance regarding participation in the network. Cigna reviews the M/S and MH/SUD provider administrative guidelines annually to confirm guidelines as written are substantially similar and comparatively implemented.

Final Rates:

The foregoing policies and supporting documents govern the establishment and application of both Base Rates and Adjusted Rates. Upon acceptance by the applicable facility or practitioner and

execution of the provider agreement, the accepted Base Rate or Adjusted Rate constitutes the Final Rate and is incorporated into the contracted fee schedule.

Step 5: Demonstration of comparability and stringency in operation.

See [45 CFR 146.137\(c\)\(5\)](#). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

- (1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:
 - (A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;
 - (B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;
 - (C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and
 - (D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);
- (2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);
- (3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

- (A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];
 - (B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);
- (4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:
- (A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and
 - (B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH and SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and
- (5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:
- (A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and
 - (B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also [FAQ 45](#) guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation

in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Relevant Data Review:

At least annually, Cigna reviews applicable operational data in consultation with qualified Subject Matter Experts to validate the data's continued relevance, reliability, completeness, and suitability for evaluating the In-Network Outpatient Reimbursement NQTL. The review requires Cigna to identify and evaluate newly available or emerging data relevant to the NQTL's operational impact and to determine, based on the totality of the available evidence, whether the NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. Cigna documents the review, its conclusions, and any identified limitations or disparities and implements timely corrective actions, including updates to data sources, methodologies, policies, procedures, or operational practices, when warranted by the findings.

Cigna does not utilize capitation, salary-based reimbursement, bundled compensation arrangements, or other alternative payment models in its reimbursement of M/S or MH/SUD INN outpatient facilities or practitioners.

Negotiated Contracts:

Data Methodology:

Cigna reviewed all Virginia outpatient professional and facility contracting matters completed during calendar year 2025 for which a standard or negotiated reimbursement rate was accepted. The review included no M/S facility contracts and 7 MH/SUD facility contract instances. Alternatively, the Outpatient Practitioner contracting population consisted of 2,273 M/S practitioner contracts and 1,621 MH/SUD practitioner contracts. Each contract was classified according to the benefit classification covered by the reimbursement arrangement. If a contract covered services in more than one benefit

classification, each applicable classification was counted separately; therefore, classification-level counts may exceed the number of unique contracts in the broader source population.

For each outpatient contract instance, Cigna identified whether the provider accepted the initial standard rate or accepted a different rate following negotiation. The acceptance percentages were calculated by dividing the number of contracts in each outcome category by the total number of outpatient contract instances reviewed for the applicable benefit category. The Virginia outpatient facility contracting population was small, consisting of no M/S facility contracts and seven MH/SUD facility contracts. Accordingly, the acceptance percentages are descriptive and are not treated as statistically stable indicators of comparative stringency.

The Virginia Outpatient Practitioner contracting population consisted of 2,273 M/S practitioner contracts and 1,621 MH/SUD practitioner contracts. With a 74% acceptance rate for Standard for M/S and a 26% negotiated acceptance rate. Alternatively, MH/SUD has a 32% acceptance rate for Standard and 68% Negotiated acceptance rate. These results demonstrate that the non-standard reimbursement process was available and frequently used for MH/SUD practitioners.

The higher frequency of negotiated MH/SUD practitioner arrangements does not indicate a more restrictive reimbursement process for MH/SUD providers. Rather, it demonstrates that MH/SUD providers had access to and utilized the same non-standard reimbursement process. The percentage of negotiated arrangements does not measure the amount of any requested or approved adjustment, the relative favorability of final reimbursement terms, or whether negotiation requests were evaluated under different standards. The review did not identify evidence that MH/SUD negotiation requests were subject to additional approval levels, different contracting factors, heightened documentation requirements, or more restrictive decision-making criteria.

Cigna therefore evaluated the available outpatient negotiations at the individual contract level, including the initial rate arrangement, whether a non-standard rate was requested, the factors considered, the negotiation history, the approval path, and the final outcome.

Outcome Data:

	Total volume of Contracts Negotiated			
	M/S		MH/SUD	
	Outpatient Office	Outpatient All - Other	Outpatient Office	Outpatient All - Other
Facility	0	0	0	7
Practitioner	2,273	0	1,621	0
	Total volume of Standard Rate offering acceptance			
	M/S		MH/SUD	
	Outpatient Office	Outpatient All - Other	Outpatient Office	Outpatient All - Other
Facility	0	0	0	3
Practitioner	2,184	0	511	0
	Percentage of Standard Rate offering acceptance based on total contracts negotiated			
	M/S		MH/SUD	
	Outpatient	Outpatient All -	Outpatient	Outpatient All -

	Office	Other	Office	Other
Facility	0	0	0	43%
Practitioner	74%	0	32%	0
	Total volume of Negotiated Rate offering acceptance			
	M/S		MH/SUD	
	Outpatient Office	Outpatient All - Other	Outpatient Office	Outpatient All - Other
	0	0	0	4
Facility	0	0	0	4
Practitioner	89	0	1,110	0
	Percentage of Negotiated Rate offering acceptance based on total contracts negotiated			
	M/S		MH/SUD	
	Outpatient Office	Outpatient All - Other	Outpatient Office	Outpatient All - Other
	0	0	0	57%
Facility	0	0	0	57%
Practitioner	26%	0	68%	0

Cigna’s individual review of the M/S and MH/SUD outpatient Practitioner and facility contract instances found that the same categories of information were considered in evaluating requests for rates, including Federal or State Law, as applicable, Provider Type, Medicare Baseline Rates, Market Dynamics, Geographic Market, Scope and Type of services, Medical Cost Budget, Utilization, Competitive insights, when available. The contracts were reviewed through the applicable contracting approval workflow and approved by the appropriate Level of Authority. The final reimbursement decisions were based on considerations of all applicable factors listed above. The review identified no material differences between M/S and MH/SUD contract negotiations in the categories of the factors considered, the types of information reviewed, the approval authorities involved, or the approval process applied. Although negotiation outcomes varied across individual contracts, the reviewed records did not identify evidence that MH/SUD contracts were subject to different factors, evidentiary requirements, review standards, or approval requirements than M/S contracts. These findings were considered together with the reimbursement outcome and access analyses described below.

Reimbursement Table A – Physician and Non-Physician:

Data Methodology: Reimbursement Table A evaluates separately billed Physician and Non-Physician services. The same claims-selection and average-reimbursement calculation methodology is applied to M/S and MH/SUD services.

For both M/S and MH/SUD, the analysis uses Virginia fully insured claims experience for calendar year 2025 and includes only claims identified as in-network based on the network-status field.

MH/SUD Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as in-network; and
- professional claims reported for the following Physician and Non-Physicians:
 - Psychiatrist;
 - Addiction Medicine Physician;
 - Psychologist; and
 - Social Worker

M/S Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as in-network; and
- professional claims reported for the following Physician and Non-Physicians:
 - o Cardiologist;
 - o Dermatologist;
 - o Chiropractor; and
 - o Physical Therapist

Average Reimbursement Calculation:

For each benefit category, average reimbursement is calculated using the same formula: **Average Reimbursement per Service Unit = Total Reimbursement Amount ÷ Total Service Units.** “Total Reimbursement Amount” means the sum of the reimbursement amount used for the included professional claim lines, and “Total Service Units” means the sum of the service units reported on those claim lines. The calculation therefore differs between M/S and MH/SUD only because of the physician and non-physician types required in the population; the formula and calculation steps are otherwise the same.

For each applicable table, average reimbursement per service unit was calculated by dividing the total allowed amount for the included claim lines by the total service units reported on those claim lines. The same calculation was applied to the M/S and MH/SUD claims populations. Any differences in the resulting average reimbursement reflect the claims included in each population, including the applicable physician types, and not a difference in the calculation methodology.

The reimbursement outcome data reflect Virginia fully insured claims experience for calendar year 2025 and uses the same calculation for both benefit categories: total allowable amount divided by total service units.

The table reports the 10 highest-volume combinations separately for each included provider. Because the selection was performed within provider categories, less than 10 total rows may appear in each benefit group.

Accordingly, the data provided an operational comparison of observed reimbursement outcomes but does not constitute a matched cohort of identical services, providers, utilization volumes, contractual terms, or case mix.

Outcome data: Reimbursement Table A MH/SUD:

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
In-Network Outpatient	Addiction Medicine Physician	Professional	99214	\$246.80	\$145.56
In-Network Outpatient	Addiction Medicine Physician	Professional	99213	\$155.42	\$77.64
In-Network Outpatient	Addiction Medicine Physician	Professional	80305	\$30.63	\$15.94
In-Network Outpatient	Addiction Medicine Physician	Professional	90833	\$141.58	\$72.36
In-Network Outpatient	Addiction Medicine Physician	Professional	99232	\$191.12	\$91.73
In-Network Outpatient	Addiction Medicine Physician	Professional	99233	\$204.02	\$125.58
In-Network Outpatient	Addiction Medicine Physician	Professional	90837	\$239.80	\$154.48
In-Network Outpatient	Addiction Medicine Physician	Professional	90792	\$386.61	\$201.54
In-Network Outpatient	Addiction Medicine Physician	Professional	96372	\$34.41	\$26.02
In-Network Outpatient	Addiction Medicine Physician	Professional	90853	\$75.68	\$58.68
In-Network Outpatient	Psychiatrist	Professional	99214	\$218.41	\$139.14
In-Network Outpatient	Psychiatrist	Professional	90833	\$150.44	\$82.57

In-Network Outpatient	Psychiatrist	Professional	99213	\$165.41	\$84.80
In-Network Outpatient	Psychiatrist	Professional	99417	\$97.45	\$50.44
In-Network Outpatient	Psychiatrist	Professional	99215	\$336.96	\$177.94
In-Network Outpatient	Psychiatrist	Professional	90868	\$1,008.60	\$245.19
In-Network Outpatient	Psychiatrist	Professional	90792	\$384.31	\$204.51
In-Network Outpatient	Psychiatrist	Professional	99233	\$221.96	\$138.05
In-Network Outpatient	Psychiatrist	Professional	99232	\$196.82	\$112.33
In-Network Outpatient	Psychiatrist	Professional	90837	\$241.16	\$190.36
In-Network Outpatient	Psychologist	Professional	90837	\$208.61	\$120.37
In-Network Outpatient	Psychologist	Professional	90834	\$175.74	\$103.89
In-Network Outpatient	Psychologist	Professional	96137	\$114.15	\$51.57
In-Network Outpatient	Psychologist	Professional	96131	\$193.77	\$105.51
In-Network Outpatient	Psychologist	Professional	90791	\$300.04	\$157.59
In-Network Outpatient	Psychologist	Professional	96139	\$98.73	\$46.23
In-Network Outpatient	Psychologist	Professional	90832	\$173.58	\$72.48
In-Network Outpatient	Psychologist	Professional	99214	\$188.33	\$137.77
In-Network Outpatient	Psychologist	Professional	96133	\$237.12	\$116.43
In-Network Outpatient	Psychologist	Professional	96130	\$189.44	\$126.50
In-Network Outpatient	Social Worker	Professional	90837	\$190.08	\$106.72
In-Network Outpatient	Social Worker	Professional	97153	\$60.99	\$18.23
In-Network Outpatient	Social Worker	Professional	90834	\$163.36	\$74.92
In-Network Outpatient	Social Worker	Professional	97155	\$77.50	\$30.76
In-Network Outpatient	Social Worker	Professional	90791	\$268.86	\$124.73
In-Network Outpatient	Social Worker	Professional	90847	\$181.87	\$94.54
In-Network Outpatient	Social Worker	Professional	97151	\$96.52	\$33.05
In-Network Outpatient	Social Worker	Professional	90832	\$132.67	\$59.26
In-Network Outpatient	Social Worker	Professional	90853	\$89.49	\$37.75
In-Network Outpatient	Social Worker	Professional	97156	\$197.15	\$46.96

M/S:

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
In-Network Outpatient	Cardiologists	Professional	Q9967	\$1.00	\$0.14
In-Network Outpatient	Cardiologists	Professional	99214	\$278.23	\$152.91
In-Network Outpatient	Cardiologists	Professional	93010	\$33.93	\$12.72
In-Network Outpatient	Cardiologists	Professional	93000	\$54.51	\$26.99
In-Network Outpatient	Cardiologists	Professional	93306	\$463.14	\$240.06
In-Network Outpatient	Cardiologists	Professional	99204	\$406.99	\$215.90
In-Network Outpatient	Cardiologists	Professional	93015	\$247.53	\$114.69
In-Network Outpatient	Cardiologists	Professional	99213	\$188.07	\$100.18
In-Network Outpatient	Cardiologists	Professional	78452	\$1,065.62	\$501.31
In-Network Outpatient	Cardiologists	Professional	99233	\$258.80	\$138.05
In-Network Outpatient	Chiropractor	Professional	98941	\$51.60	\$30.29
In-Network Outpatient	Chiropractor	Professional	97014	\$27.47	\$11.45
In-Network Outpatient	Chiropractor	Professional	97110	\$24.89	\$16.12
In-Network Outpatient	Chiropractor	Professional	98940	\$36.34	\$28.08
In-Network Outpatient	Chiropractor	Professional	97140	\$43.41	\$19.35
In-Network Outpatient	Chiropractor	Professional	97012	\$23.09	\$10.67
In-Network Outpatient	Chiropractor	Professional	98943	\$81.92	\$32.27
In-Network Outpatient	Chiropractor	Professional	97530	\$22.00	\$14.17
In-Network Outpatient	Chiropractor	Professional	99203	\$91.28	\$46.07
In-Network Outpatient	Chiropractor	Professional	97112	\$32.94	\$26.40
In-Network Outpatient	Dermatologists	Professional	99213	\$203.65	\$83.91
In-Network Outpatient	Dermatologists	Professional	99214	\$280.37	\$120.98
In-Network Outpatient	Dermatologists	Professional	17003	\$29.32	\$7.61
In-Network Outpatient	Dermatologists	Professional	17110	\$286.14	\$124.47
In-Network Outpatient	Dermatologists	Professional	99203	\$282.56	\$112.49
In-Network Outpatient	Dermatologists	Professional	99204	\$417.05	\$161.99
In-Network Outpatient	Dermatologists	Professional	17000	\$184.76	\$64.50

In-Network Outpatient	Dermatologists	Professional	11102	\$258.42	\$105.96
In-Network Outpatient	Dermatologists	Professional	J3301	\$13.00	\$1.25
In-Network Outpatient	Dermatologists	Professional	11900	\$150.34	\$58.49
In-Network Outpatient	Physical Therapists	Professional	97110	\$94.41	\$32.94
In-Network Outpatient	Physical Therapists	Professional	97112	\$99.64	\$37.74
In-Network Outpatient	Physical Therapists	Professional	97140	\$91.01	\$30.71
In-Network Outpatient	Physical Therapists	Professional	97530	\$108.21	\$42.06
In-Network Outpatient	Physical Therapists	Professional	97161	\$242.66	\$97.06
In-Network Outpatient	Physical Therapists	Professional	97535	\$95.85	\$41.44
In-Network Outpatient	Physical Therapists	Professional	97162	\$266.40	\$98.62
In-Network Outpatient	Physical Therapists	Professional	97014	\$43.83	\$17.95
In-Network Outpatient	Physical Therapists	Professional	97164	\$143.67	\$66.70
In-Network Outpatient	Physical Therapists	Professional	97016	\$52.87	\$18.70

Table A compares MH/SUD practitioners—addiction medicine physicians, psychiatrists, psychologists, and social workers—with M/S cardiologists, chiropractors, dermatologists, and physical therapists.

- MH/SUD average allowable amounts range from \$15.94 to \$245.19 per unit.
- M/S average allowable amounts range from \$0.14 to \$501.31 per unit.
- The broader M/S range is driven by the inclusion of low-cost supplies, injections, testing components, and higher-cost cardiology procedures. MH/SUD services are more concentrated in evaluation and management, psychotherapy, psychological testing, and behavioral treatment codes.

For the shared evaluation and management codes, MH/SUD falls within the reported M/S range for CPT 99214 and 99233. Direct comparison of allowed amounts across specialties is inherently limited because reimbursement varies based on provider specialty, service code, relative value units, site of service, contractual terms, network needs, and geographic adjustments. However, the data do not establish that the difference results from a more stringent MH/SUD reimbursement standard. Specialty-specific fee schedules, relative value units, geographic adjustments, provider contracts, modifiers, service setting, and negotiated arrangements may produce different allowable amounts for the same procedure code.

Table A demonstrates meaningful variation both within and between MH/SUD and M/S provider specialties. Although certain MH/SUD results are lower than certain M/S results, other MH/SUD results equal or exceed the corresponding M/S amounts.

The review did not identify evidence that differences in reimbursement outcomes resulted from the application of different reimbursement methodologies, contracting factors, approval requirements, documentation standards, negotiation processes, or operational controls for MH/SUD professional services.

Reimbursement Table C – Professional Services Rendered in Facility Setting:

Data Methodology: Reimbursement Table C evaluates separately billed professional services rendered in an outpatient facility setting. The same claims-selection and average-reimbursement calculation methodology is applied to M/S and MH/SUD services. The only difference is the set of place-of-service (“POS”) codes and claims service type specific to Intensive Outpatient Facility used to identify the outpatient settings applicable to each benefit category.

For both M/S and MH/SUD, the analysis uses Virginia fully insured claims experience for calendar year 2025 and includes only claims identified as in-network based on the network-status field. Professional claims are assigned to the In-Network outpatient classification using the POS code and claims service

type specific to Intensive Outpatient Facility reported on the claim. The applicable POS codes and claims service type specific to Intensive Outpatient Facility are identified below.

MH/SUD Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as in-network; and
- professional claims reported with one of the following POS codes:
 - Psych Fac – Partial Hosp (POS 52);
 - Non-Residential SA Fac (POS 57);
 - On-Campus OP Hospital (POS 22);
 - Intensive Outpatient Facility (Partial Hospitalization and Intensive Outpatient Programs)

M/S Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as in-network; and
- professional claims reported with one of the following POS codes:
 - Ambulatory Surgical Center (POS 24);
 - ESRD Treatment Facility (POS 65);
 - On-Campus OP Hospital (POS 22).

Average Reimbursement Calculation:

For each benefit category, average reimbursement is calculated using the same formula: **Average Reimbursement per Service Unit = Total Reimbursement Amount ÷ Total Service Units**. “Total Reimbursement Amount” means the sum of the reimbursement amount used for the included professional claim lines, and “Total Service Units” means the sum of the service units reported on those claim lines. The calculation therefore differs between M/S and MH/SUD only because each category includes the POS codes applicable to its outpatient professional services population; the formula and calculation steps are otherwise the same.

For each applicable table, average reimbursement per service unit was calculated by dividing the total allowed amount for the included claim lines by the total service units reported on those claim lines. The same calculation was applied to the M/S and MH/SUD claims populations. Any differences in the resulting average reimbursement reflect the claims included in each population, including the applicable place-of-service codes, and not a difference in the calculation methodology.

The reimbursement outcome data reflect Virginia fully insured claims experience for calendar year 2025 and uses the same calculation for both benefit categories: total billed or allowable amount divided by total service units.

The table reports the 10 highest-volume combinations separately for each included provider. Because the selection was performed within provider categories, less than 10 total rows may appear in each benefit group.

Accordingly, the data provided an operational comparison of observed reimbursement outcomes but does not constitute a matched cohort of identical services, providers, utilization volumes, contractual terms, or case mix.

Reimbursement Table C

MH/SUD

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE	AVERAGE BILLED	AVERAGE ALLOWED
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			CODE	AMOUNT PER UNIT	AMOUNT PER UNIT
In-Network Outpatient	Intensive Outpatient Facility	Facility	H0015	\$799.32	\$243.45
In-Network Outpatient	Intensive Outpatient Facility	Facility	H0020	\$30.00	\$30.00
In-Network Outpatient	Intensive Outpatient Facility	Facility	S9480	\$1,884.27	\$356.36
In-Network Outpatient	Intensive Outpatient Facility	Facility	H0035	\$1,445.00	\$741.00
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	H0020	\$76.61	\$28.05
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	G0410	\$615.16	\$121.88
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	S9480	\$1,356.56	\$418.97
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	H0015	\$1,144.43	\$228.17
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	H2036	\$2,479.44	\$425.93
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	90853	\$350.97	\$197.15
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	H0035	\$1,613.23	\$613.11
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	80305	\$111.00	\$63.49
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	82075	\$500.00	\$250.00
In-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	S0201	\$1,447.54	\$384.49

M/S:

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
In-Network Outpatient	Ambulatory Surgical Center	Facility	490	\$5,670.09	\$1,654.76
In-Network Outpatient	Ambulatory Surgical Center	Facility	278	\$3,388.64	\$1,370.42
In-Network Outpatient	Ambulatory Surgical Center	Facility	636	\$939.07	\$286.97
In-Network Outpatient	Ambulatory Surgical Center	Facility	320	\$296.00	\$37.86
In-Network Outpatient	Ambulatory Surgical Center	Facility	790	\$7,400.00	\$4,860.00
In-Network Outpatient	Ambulatory Surgical Center	Facility	272	\$5,284.38	\$114.18
In-Network Outpatient	ESRD Treatment Facility	Facility	821	\$9,582.64	\$1,304.72
In-Network Outpatient	ESRD Treatment Facility	Facility	851	\$4,383.11	\$562.16
In-Network Outpatient	ESRD Treatment Facility	Facility	636	\$1,986.36	\$21.05
In-Network Outpatient	ESRD Treatment Facility	Facility	841	\$4,407.12	\$625.73
In-Network Outpatient	On-Campus OP Hospital	Facility	80053	\$402.00	\$77.19
In-Network Outpatient	On-Campus OP Hospital	Facility	85025	\$181.37	\$21.26
In-Network Outpatient	On-Campus OP Hospital	Facility	97110	\$153.90	\$53.48
In-Network Outpatient	On-Campus OP Hospital	Facility	99284	\$2,849.50	\$1,130.84
In-Network Outpatient	On-Campus OP Hospital	Facility	85027	\$289.20	\$10.81
In-Network Outpatient	On-Campus OP Hospital	Facility	93005	\$560.78	\$61.20
In-Network Outpatient	On-Campus OP Hospital	Facility	97530	\$170.62	\$55.70
In-Network Outpatient	On-Campus OP Hospital	Facility	84484	\$307.16	\$22.34
In-Network Outpatient	On-Campus OP Hospital	Facility	99283	\$2,137.57	\$1,181.45

In-Network Outpatient	On-Campus OP Hospital	Facility	J1885	\$70.47	\$4.71
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Table C compares MH/SUD psychiatric partial-hospitalization, substance-use-disorder, and on-campus outpatient hospital services with M/S ambulatory surgical center, ESRD treatment facility, and on-campus outpatient hospital services.

- MH/SUD average billed amounts range from \$30.00 to \$2,479.44 per unit, and average allowed amounts range from \$28.05 to \$741.00 per unit.
- M/S average billed amounts range from \$70.47 to \$9,582.64 per unit, and average allowed amounts range from \$4.71 to \$4,860.00 per unit.
- The MH/SUD rows principally reflect intensive outpatient treatment, opioid treatment services, partial hospitalization, group psychotherapy, behavioral health treatment, substance-use testing, and related outpatient services.
- The M/S rows include ambulatory surgical center services, dialysis-related services, laboratory testing, therapeutic procedures, and other outpatient institutional services.
- One MH/SUD row—procedure code H0020 furnished by an Intensive Outpatient Facility—has an average billed amount and average allowed amount of \$30.00 per unit, representing an allowed-to-billed relationship of 100%.
- Other MH/SUD allowed-to-billed relationships vary by code and setting. For example, Intensive Outpatient Facility code H0035 has an average allowed amount of \$741.00, representing approximately 51.28% of the \$1,445.00 average billed amount. On-Campus Outpatient Hospital code H2036 has an average allowed amount of \$425.93, representing approximately 17.18% of the \$2,479.44 average billed amount.
- M/S rows likewise demonstrate substantial variation in the relationship between average billed and allowed amounts. Ambulatory Surgical Center code 790 has an average allowed amount of \$4,860.00, representing approximately 65.68% of the \$7,400.00 average billed amount. By contrast, ESRD Treatment Facility code 636 has an average allowed amount of \$21.05, representing approximately 1.06% of the \$1,986.36 average billed amount. Among the M/S On-Campus Outpatient Hospital rows, the allowed-to-billed relationship ranges from approximately 3.74% for code 85027 to approximately 55.27% for code 99283.

There are no directly matched procedure codes between the MH/SUD and M/S portions of Table C. Although both datasets include On-Campus Outpatient Hospital services, the reported codes represent materially different services.

- The MH/SUD rows include intensive outpatient, partial hospitalization, group psychotherapy, behavioral health treatment, and substance-use-related testing and treatment services.
- The M/S On-Campus Outpatient Hospital rows include laboratory testing, therapeutic procedures, emergency department services, and medication administration. The M/S dataset also includes Ambulatory Surgical Center and ESRD Treatment Facility services that have no corresponding provider-setting category in the MH/SUD dataset.

Differences in billed and allowable amounts primarily reflect differences in service mix, provider setting, coding structure, unit definitions, and contractual reimbursement methodologies. The review did not identify evidence that MH/SUD services were subject to different reimbursement methodologies, approval requirements, documentation standards, or negotiation processes than comparable M/S services.

Reimbursement Table D – Emergency Services:

Emergency services data per the VA requirements is being included in the INN Reimbursement NQTL due to all emergency services being reimbursed at the plans in-network benefit level based on applicable state and federal law.

Data Methodology: Reimbursement Table D evaluates separately billed emergency services. The same claims-selection and average-reimbursement calculation methodology is applied to M/S and MH/SUD services. The only difference is the set of place-of-service (“POS”) codes used to identify the emergency settings applicable to each benefit category.

For both M/S and MH/SUD, the analysis uses Virginia fully insured claims experience for calendar year 2025 and includes only claims identified as in-network based on the network-status field. Professional claims are assigned to the Emergency classification using the POS code or procedure code for Mobile Crisis Response, RCSU and Crisis Receiving Center reported on the claim. The applicable POS codes and procedure codes are identified below.

MH/SUD Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as in-network; and
- professional claims reported with one of the following POS codes:
 - Emergency Room (POS 23)
 - Ambulance - Land (POS 41)
 - Ambulance – Air or Water (POS 42)
 - Mobile Crisis Response (Services identified using procedure codes H0011, H2015, and H2011)
 - RCSU (Services identified using procedure codes H0018, T2048, and H2018)
 - Crisis Receiving Center (Services identified using procedure code S9485)

M/S Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as in-network; and
- professional claims reported with one of the following POS codes:
 - Emergency Room (POS 23)
 - Ambulance – Land (POS 41)
 - Ambulance – Air or Water (POS 42)

Average Reimbursement Calculation:

For each benefit category, average reimbursement is calculated using the same formula: **Average Reimbursement per Service Unit = Total Reimbursement Amount ÷ Total Service Units**. “Total Reimbursement Amount” means the sum of the reimbursement amount used for the included professional claim lines, and “Total Service Units” means the sum of the service units reported on those claim lines. The calculation therefore differs between M/S and MH/SUD only because each category includes the POS codes and procedure code for Mobile Crisis Response, RCSU and Crisis Receiving Center applicable to its emergency services population; the formula and calculation steps are otherwise the same.

For each applicable table, average reimbursement per service unit was calculated by dividing the total

allowed amount for the included claim lines by the total service units reported on those claim lines. The same calculation was applied to the M/S and MH/SUD claims populations. Any differences in the resulting average reimbursement reflect the claims included in each population, including the applicable place-of-service codes and procedure codes, and not a difference in the calculation methodology.

The reimbursement outcome data reflects Virginia fully insured claims experience for calendar year 2025 and uses the same calculation for both benefit categories: total billed or allowable amount divided by total service units. The table reports the 10 highest-volume combinations separately for each included provider. Because the selection was performed within provider categories, less than 10 total rows may appear in each benefit group.

Accordingly, the data provided an operational comparison of observed reimbursement outcomes but does not constitute a matched cohort of identical services, providers, utilization volumes, contractual terms, or case mix.

Reimbursement Table D

MH/SUD:

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
Emergency	Ambulance Air/Water	Professional	A0431	\$43,442.75	\$21,168.22
Emergency	Ambulance Air/Water	Professional	A0436	\$18,476.75	\$7,678.44
Emergency	Ambulance Land	Professional	A0425	\$225.29	\$141.47
Emergency	Ambulance Land	Professional	A0427	\$1,134.57	\$780.38
Emergency	Ambulance Land	Professional	A0429	\$856.95	\$637.84
Emergency	Ambulance Land	Professional	A0428	\$1,196.42	\$423.63
Emergency	Ambulance Land	Professional	A0426	\$1,729.50	\$565.74
Emergency	Ambulance Land	Professional	A0998	\$198.10	\$197.38
Emergency	Ambulance Land	Professional	A0433	\$1,666.08	\$974.46
Emergency	Ambulance Land	Professional	A0434	\$4,300.16	\$1,402.24
Emergency	Emergency Room	Professional	99285	\$1,426.75	\$486.59
Emergency	Emergency Room	Professional	99284	\$960.72	\$316.84
Emergency	Emergency Room	Professional	93010	\$75.51	\$14.02
Emergency	Emergency Room	Professional	71045	\$44.05	\$13.07
Emergency	Emergency Room	Professional	80053	\$41.12	\$16.55
Emergency	Emergency Room	Professional	85025	\$30.65	\$12.37
Emergency	Emergency Room	Professional	74177	\$490.59	\$139.86
Emergency	Emergency Room	Professional	70450	\$209.04	\$60.62
Emergency	Emergency Room	Professional	84484	\$33.53	\$19.41
Emergency	Emergency Room	Professional	99283	\$517.88	\$164.57

M/S:

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
Emergency	Ambulance Air/Water	Professional	A0431	\$43,442.75	\$21,168.22
Emergency	Ambulance Air/Water	Professional	A0436	\$18,476.75	\$7,678.44
Emergency	Ambulance Land	Professional	A0425	\$225.29	\$141.47
Emergency	Ambulance Land	Professional	A0427	\$1,134.57	\$780.38
Emergency	Ambulance Land	Professional	A0429	\$856.95	\$637.84
Emergency	Ambulance Land	Professional	A0428	\$1,196.42	\$423.63
Emergency	Ambulance Land	Professional	A0426	\$1,729.50	\$565.74
Emergency	Ambulance Land	Professional	A0998	\$198.10	\$197.38
Emergency	Ambulance Land	Professional	A0433	\$1,666.08	\$974.46
Emergency	Ambulance Land	Professional	A0434	\$4,300.16	\$1,402.24
Emergency	Emergency Room	Professional	99285	\$1,426.75	\$486.59
Emergency	Emergency Room	Professional	99284	\$960.72	\$316.84

Emergency	Emergency Room	Professional	93010	\$75.51	\$14.02
Emergency	Emergency Room	Professional	71045	\$44.05	\$13.07
Emergency	Emergency Room	Professional	80053	\$41.12	\$16.55
Emergency	Emergency Room	Professional	85025	\$30.65	\$12.37
Emergency	Emergency Room	Professional	74177	\$490.59	\$139.86
Emergency	Emergency Room	Professional	70450	\$209.04	\$60.62
Emergency	Emergency Room	Professional	84484	\$33.53	\$19.41
Emergency	Emergency Room	Professional	99283	\$517.88	\$164.57
CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
Emergency	Emergency Room	Facility	99284	\$2,850.17	\$1,131.00
Emergency	Emergency Room	Facility	99283	\$2,137.57	\$1,181.45
Emergency	Emergency Room	Facility	99285	\$3,731.26	\$1,417.66
Emergency	Emergency Room	Facility	96374	\$705.96	\$20.63
Emergency	Emergency Room	Facility	96375	\$875.08	\$14.20
Emergency	Emergency Room	Facility	96361	\$482.84	\$14.51
Emergency	Emergency Room	Facility	99282	\$1,187.74	\$599.78
Emergency	Emergency Room	Facility	96372	\$346.53	\$6.88
Emergency	Emergency Room	Facility	96376	\$737.38	\$6.39
Emergency	Emergency Room	Facility	96360	\$944.31	\$15.01

Table D compares emergency services reported for MH/SUD professional air/water ambulance, land ambulance, and emergency room services with M/S data professional ambulance and emergency room services, as well as a separate group of emergency room facility services.

- MH/SUD average billed amounts range from \$30.65 to \$43,442.75 per unit, and average allowed amounts range from \$12.37 to \$21,168.22 per unit.
- M/S average billed amounts range from \$30.65 to \$43,442.75 per unit, and average allowed amounts range from \$6.39 to \$21,168.22 per unit when the additional M/S emergency room facility rows are included.
- The highest billed and allowed amounts in both benefit categories are associated with air/water ambulance services. Procedure code A0431 has an average billed amount of \$43,442.75 and an average allowed amount of \$21,168.22, while procedure code A0436 has an average billed amount of \$18,476.75 and an average allowed amount of \$7,678.44.
- These ambulance amounts should not be compared directly with emergency room evaluation and management, laboratory, imaging, or other professional and facility services because the services differ materially in coding, resource requirements, unit definitions, and reimbursement methodology.
- The relationship between billed and allowed amounts varies by code. For example, land ambulance code A0998 has an average allowed amount of \$197.38, representing approximately 99.64% of the \$198.10 average billed amount. By contrast, emergency room professional code 93010 has an average allowed amount of \$14.02, representing approximately 18.57% of the \$75.51 average billed amount.
- The M/S-only emergency room facility rows also demonstrate substantial variation. Facility code 99283 has an average allowed amount of \$1,181.45, representing approximately 55.27% of the \$2,137.57 average billed amount, while facility code 96376 has an average allowed amount of \$6.39, representing approximately 0.87% of the \$737.38 average billed amount.

The professional portions of the MH/SUD and M/S datasets are directly matched. Each benefit category includes the same 20 professional procedure codes across the same air/water ambulance, land ambulance, and emergency room provider settings. For every matched professional code, the reported average billed amount and average allowed amount are identical for MH/SUD and M/S. This

includes:

- Air/water ambulance codes A0431 and A0436;
- Land ambulance codes A0425, A0427, A0429, A0428, A0426, A0998, A0433, and A0434; and
- Emergency room professional codes 99285, 99284, 93010, 71045, 80053, 85025, 74177, 70450, 84484, and 99283.

Because the same professional procedure codes produced identical average billed and average allowed amounts across M/S and MH/SUD benefits, the Table D results provide direct evidence that the reimbursement methodology operated comparably for the emergency professional services evaluated.

For example, professional code 99285 has an average billed amount of \$1,426.75 and an average allowed amount of \$486.59 for both MH/SUD and M/S, representing approximately 34.10% of the average billed amount in each benefit category. Professional code 99284 likewise has an average billed amount of \$960.72 and an average allowed amount of \$316.84 for both benefit categories, and professional code 99283 has an average billed amount of \$517.88 and an average allowed amount of \$164.57 for both benefit categories.

The additional M/S emergency room facility rows are not directly comparable with the MH/SUD professional rows because Table D does not report corresponding MH/SUD facility-component claims. Professional and facility claims represent distinct reimbursement components and may be subject to different fee schedules, contractual arrangements, unit definitions, and payment methodologies. Accordingly, the M/S facility rows should not be combined with or substituted for the directly matched professional comparison.

The directly matched professional results indicate MH/SUD and M/S benefits have identical average billed and allowed amounts for every professional procedure code reported in both datasets. Table D demonstrates that the reimbursement NQTL was applied comparably and no more stringently to MH/SUD emergency services than to M/S emergency services.

Reimbursement Rates; outpatient - all other facility services

Cigna conducted a comparison of reimbursement rates of M/S facilities compared to MH/SUD for in-network facility-based services. To conduct the comparative analysis of in-network facility reimbursement Cigna utilized a subset of 2025 in-network claims data with the following criteria:

- Targeted Ambulatory Payment Classification (APC) (Outpatient), limited to allow for comparison of like M/S to MH/SUD services
 - M/S
 - 00807 – VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITHOUT CC/MCC
 - 00806 – VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH CC
 - 00057 – DEGENERATIVE NERVOUS SYSTEM DISORDERS WITHOUT MCC
 - 00768 – VAGINAL DELIVERY WITH O.R. PROCEDURES EXCEPT STERILIZATION AND/OR D&C
 - 00805 – VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH MCC
 - 00056 – DEGENERATIVE NERVOUS SYSTEM DISORDERS WITH MCC
 - 00189 – PULMONARY EDEMA AND RESPIRATORY FAILURE
 - 00561 – AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT CC/MCC
 - 00641 - MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND

ELECTROLYTES

- 00392 – ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS
- DIGESTIVE DISORDERS WITHOUT MCC
- 00798 VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITHOUT CC/MCC
- 00603 CELLULITIS WITHOUT MCC
- 00640 MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND ELECTROLYTES WITH MCC
- 00797 VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH CC
- 00176 - PULMONARY EMBOLISM WITHOUT MCC
- 00796 - VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH MCC
- 00312 – SYNCOPE AND COLLAPSE
- 05012 – CLINIC VISITS AND RELATED SERVICES
- 05771 – CARDIAC REHABILITATION
- 05061 – HYPERBARIC OXYGEN
- 08011 – COMPREHENSIVE OBSERVATION SERVICES

○ MH/SUD

- 00885 – PSYCHOSES
 - 00897 – ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITHOUT MCC
 - 00881 - DEPRESSIVE NEUROSES
 - 00882 – NEUROSES EXCEPT DEPRESSIVE
 - 00883 – DISORDERS OF PERSONALITY AND IMPULSE CONTROL
 - 00880 – ACUTE ADJUSTMENT REACTION AND PSYCHOSOCIAL DYSFUNCTION
 - 00886 – BEHAVIORAL AND DEVELOPMENTAL DISORDERS
 - 00884 – ORGANIC DISTURBANCES AND INTELLECTUAL DISABILITY
 - 00896 – ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITH MCC
 - 00876 – O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS
 - 05823 – LEVEL 3 HEALTH AND BEHAVIOR SERVICES
 - 05822 – LEVEL 2 HEALTH AND BEHAVIOR SERVICES
 - 05012 – CLINIC VISITS AND RELATED SERVICES
 - 05821 – LEVEL 1 HEALTH AND BEHAVIOR SERVICES
- CMS National pricing methodology
 - CMS pricer did not generate an error when pricing claim (i.e., CMS allows for reimbursement. An example of an excluded service is MH/SUD Residential Treatment, as that is not reimbursable by CMS)

The following items were excluded to allow for MH/SUD and M/S like services to be compared:

- Interim and split claims
- Patient Age <1
- ER claims
- Surgery claims (except maternity)
- ICU claims
- Claims with precertification penalty
- Children's Hospital.

The results listed below show that M/S Outpatient Facility claims were paid at 304% of CMS allowable, while MH/SUD Outpatient Facility claims were paid at 278% of CMS, both substantially exceeding the CMS benchmark. The aggregate results are descriptive and are not treated as a compliance threshold. The fact that reimbursement exceeded the modeled CMS amount does not independently demonstrate comparability or compliance. Cigna evaluated the observed difference together with service mix, APC distribution, provider and facility type, geographic distribution, contract methodology, claim volume, and the application of negotiation and approval requirements. Because the analysis was not designed as a matched comparison of clinically identical services and was not adjusted for differences in facility type, APC mix, utilization patterns, geographic distribution, contractual reimbursement methodology, or claim composition, the observed difference was not interpreted as indicating differential application of the reimbursement NQTL.

Facility Reimbursement Details						Cigna	CMS
Type Of Claim	CATEGORY	Cigna \$Allowed	CMS \$Allowed	CMS %	Claim Count	\$ Per Claim	\$ Per Claim
OP	M/S	\$217,273,318	\$71,418,814	304%	416,757	\$521	\$171
OP	MH/SUD	\$28,652,811	\$10,299,573	278%	44,188	\$648	\$233

Because aggregate reimbursement percentages are heavily influenced by APC mix, facility type, geographic distribution, negotiated reimbursement methodologies, and claim composition, Cigna did not evaluate the results using a predetermined parity threshold. Instead, the data were reviewed to determine whether reimbursement outcomes reflected the operation of comparable reimbursement methodologies and contracting processes.

The significant difference in claim volume between M/S and MH/SUD facility services was considered when interpreting aggregate reimbursement results because a smaller claim population may result in greater sensitivity to facility-specific contracting arrangements. The review did not identify evidence that differences in aggregate reimbursement outcomes resulted from the application of different reimbursement methodologies, contracting factors, approval requirements, documentation standards, negotiation processes, or operational controls for MH/SUD facility services.

Reimbursement Rates; outpatient office visit services:

Cigna has assessed the reimbursement rates paid across its Virginia and Cigna Commercial book-of-business by reference to reimbursement data in 2025. In its assessment, Cigna identified variances in provider reimbursement rates between M/S and MH/SUD providers. The reimbursement review identified variation in reimbursement outcomes among provider types and services. Differences in reimbursement outcomes may reflect numerous neutral, provider-specific factors including provider type, licensure, scope of service, market conditions, utilization patterns, network need, provider-specific negotiations, geographic considerations, and applicable reimbursement benchmarks.

In its evaluation, Cigna compiled mean reimbursement rates from claims data submitted by providers servicing locations in Virginia that included: primary care level MD and non-MD mid-level providers (i.e., Physician Assistants, Advanced Practice Registered Nurses) claims and behavioral health MD level

psychiatrists and non-MD level psychologist and Licensed Clinical Social Workers (LCSWs) claims. The mean reimbursement was compared to Medicare rates to calculate the percent of Medicare ratio.

For purposes of the operational comparison, Cigna selects procedure codes that are consistent with the DOL Self-Compliance Tool's MHPAEA comparative analysis framework and that are representative of outpatient professional services routinely subject to the reimbursement methodology evaluated in this analysis. The selected codes are intended to provide a reasonable and administrable basis for comparing how the reimbursement NQTL operates across M/S and MH/SUD services, including whether comparable reimbursement methodologies, contracting factors, evidentiary standards, negotiation processes, and approval controls are applied.

The selected codes are representative outpatient professional services that are consistent with the DOL Self-Compliance Tool framework and routinely subject to the reimbursement methodology evaluated in this analysis.

CPT codes 99213 and 99203 are commonly used outpatient evaluation and management codes billed by physicians across both M/S and MH/SUD specialties and therefore provide a direct and administrable basis for comparing physician-level professional reimbursement.

For non-physician providers, there are not similarly shared CPT codes used across both M/S and MH/SUD specialties. Accordingly, CPT 90791 was selected as a representative psychiatric diagnostic evaluation service, and CPT 90832 was selected as a representative individual psychotherapy service. These codes are not clinically equivalent to M/S evaluation and management codes and are therefore used to evaluate the operation of reimbursement processes for representative services, rather than to compare payment amounts for identical services.

Cigna compared M/S primary care physicians to MH/SUD psychiatrists as the physician-level comparison group. For the non-physician comparison, Cigna compared M/S mid-level practitioners to MH/SUD non-physician practitioners, including psychologists and licensed clinical social workers ("LCSWs"). After identifying the comparable provider groups, Cigna selected representative service codes within each benefit category to assess the application of the reimbursement related NQTL. For M/S services Cigna selected CPT codes 99213 and 99203, which are commonly used outpatient office evaluation and management services. For MH/SUD services, Cigna selected and CPT codes 90791 and 90832, which are commonly used psychiatric diagnostic evaluation services. These codes were selected because they are frequently rendered by the relevant provider types are specific to the respective M/S and MH/SUD billing frameworks and provide an appropriate basis for comparing how reimbursement methodologies are designed and applied across benefit classifications.

The purpose of selecting these codes was not to establish clinical equivalency between particular MH/SUD and M/S services. Rather, the codes were used as representative examples, to evaluate whether Cigna applied comparable reimbursement methodologies, contracting processes, negotiation standards, approval requirements, and governance controls to outpatient professional services within the benefit classification.

CPT codes 90791 and 90832 were selected because they are among the most commonly utilized MH/SUD diagnostic evaluation services and represent core professional behavioral health services routinely subject to outpatient practitioner reimbursement methodologies.

CPT codes 99213 and 99203 were selected because they are among the most commonly utilized M/S outpatient office evaluation and management services and similarly represent core

professional practitioner services subject to the same reimbursement methodology review.

For each selected code, reimbursement rates were developed, negotiated, reviewed, and approved under the same overall reimbursement framework, including Medicare-based methodologies where applicable, market and geographic considerations, contracting procedures, approval requirements for non-standard reimbursement arrangements, and governance controls. The selected codes provide representative, but not clinically equivalent, examples of professional services within the applicable outpatient subclassification. The comparison is used to evaluate the operation of the reimbursement processes across selected provider types and services and is not intended as a direct comparison of payment amounts for equivalent services.

Accordingly, the selected service codes serve as illustrative and operationally relevant examples for evaluating the comparability and stringency of the reimbursement NQTL as applied to representative outpatient professional services. They are not intended to function as direct clinical matches but they support a legally meaningful comparison of whether the same reimbursement-related standards and controls were applied consistently across MH/SUD and M/S services.

Cigna has provided the specific CPT reimbursement information requested in the table set forth below:

Below:

Virginia 2025 Book of Business M/S Non-Facility In-Network Professional Services					
Provider Type	Provider Type Code	CPT Code	Mean Reimbursement	Medicare (or Cigna RBRVS) Reimbursement	% of Medicare
Internists MD	IM	99203	\$130.80	\$107.01	122.24%
		99213	\$92.93	\$87.55	106.14%
General Practice MD	GP	99203	\$114.25	\$107.01	106.77%
		99213	\$91.13	\$87.55	104.09%
Family Practice MD	FP	99203	\$113.94	\$107.01	106.47%
		99213	\$91.82	\$87.55	104.88%
Mid-Levels	FA, NF, NG, NH, NS	99203	\$128.82	\$107.01	120.39%
		99213	\$90.37	\$87.55	103.22%
Virginia 2025 Book of Business MH/SUD Non-Facility In-Network Professional Services					
Psychiatrists		99203*	\$140.62	\$107.01	131.41%
		99213	\$83.38	\$87.55	95.23%
Child Psychiatrists	No code; manual derivation	99203	No claims	No claims	No claims
		99213**	\$116.48	\$87.55	133.05%
Psychologists		90832	\$73.30	\$78.45	93.43%
		90791	\$158.11	\$165.73	95.40%
LCSW		90832	\$59.43	\$78.45	75.75%
		90791	\$125.15	\$165.73	75.51%

*<10 visits

**<50 visits

The reimbursement percentages shown for psychologists and LCSWs reflect provider-specific Medicare reimbursement methodologies and service codes that differ from the physician evaluation and management services used in the M/S comparison group and therefore should not be interpreted as evidence that reimbursement standards or contracting requirements were applied more restrictively to MH/SUD providers.

The reimbursement percentages reported above reflect different provider types, service codes, Medicare reimbursement methodologies, and billing frameworks. The analysis was not designed as a

comparison of clinically equivalent services or as a determination that reimbursement should fall within any particular percentage range relative to Medicare. Instead, the analysis evaluates whether reimbursement methodologies, contracting factors, negotiation opportunities, approval requirements, and governance processes operate comparably across M/S and MH/SUD provider groups.

Operational Testing Results

Based on the above tables, the reimbursement comparison does not indicate that Cigna uses a reimbursement methodology that is facially or operationally more stringent for MH/SUD professional providers than for M/S professional providers. The tables compare mean in-network reimbursement with the applicable Medicare or Cigna RBRVS benchmark for selected M/S and MH/SUD non-facility professional services in the Virginia 2025 Book of Business.

For the M/S comparison set, reimbursement for the evaluation and management codes shown ranged from 103.22% to 122.24% of the applicable benchmark, depending on provider type and CPT code. Internists were reimbursed at 122.24% of benchmark for CPT 99203 and 106.14% for CPT 99213. General practice physicians were reimbursed at 106.77% for CPT 99203 and 104.09% for CPT 99213. Family practice physicians were reimbursed at 106.47% for CPT 99203 and 104.88% for CPT 99213. Mid-level providers were reimbursed at 120.39% for CPT 99203 and 103.22% for CPT 99213. Each reported M/S result exceeded the applicable Medicare or Cigna RBRVS benchmark.

For the MH/SUD comparison set, reimbursement ranged from 75.51% to 133.05% of the applicable benchmark, excluding child psychiatrist CPT 99203, for which no claims were reported. Psychiatrists were reimbursed at 131.41% of benchmark for CPT 99203 and 95.23% for CPT 99213. No claims were reported for child psychiatrists for CPT 99203. Child psychiatrists were reimbursed at 133.05% of benchmark for CPT 99213; this result was based on fewer than 50 visits. Psychologists were reimbursed at 93.43% of benchmark for CPT 90832 and 95.40% for CPT 90791. LCSWs were reimbursed at 75.75% of benchmark for CPT 90832 and 75.51% for CPT 90791.

The physician evaluation and management results provide the most direct comparison between MH/SUD and M/S services because the tables report the same CPT codes against the same benchmark amounts. For CPT 99203, psychiatrist reimbursement was 131.41% of benchmark, exceeding the M/S range of 106.47% to 122.24% for the same code. For CPT 99213, psychiatrist reimbursement was 95.23% of benchmark, below the M/S range of 103.22% to 106.14%, while child psychiatrist reimbursement was 133.05%, above the M/S range. These mixed results do not demonstrate a uniform or categorical pattern of lower reimbursement for MH/SUD physicians. Rather, the results reflect variation by provider type and claims experience, including limited volume for the psychiatrist CPT 99203 and child psychiatrist CPT 99213 results.

Although the psychologist and LCSW services shown were reimbursed below their applicable benchmarks, CPT 90832 and CPT 90791 are psychotherapy and psychiatric diagnostic evaluation services and are not directly comparable to the M/S evaluation and management codes included in the table. In addition, reimbursement percentages may vary based on provider type, professional licensure, service code, relative value, applicable fee schedule, contractual terms, geographic adjustments, network considerations, and other reimbursement factors. Accordingly, a below-benchmark result for an individual MH/SUD provider type or service does not, standing alone, establish that the reimbursement methodology or its underlying processes were applied more stringently to MH/SUD benefits.

Taken together, the operational testing results do not show a categorical reduction applicable to MH/SUD professional services or a consistent pattern of less favorable treatment. The reported MH/SUD results include physician services reimbursed both above and below benchmark, including psychiatrist CPT 99203 at 131.41% and child psychiatrist CPT 99213 at 133.05%. The lower percentages reported for psychologists and LCSWs involve different provider types and service codes and therefore do not establish a directly comparable disparity relative to the M/S evaluation and management results. Based on the submitted data, the reimbursement outcomes are consistent with provider- and service-specific variation rather than a separate or more restrictive reimbursement methodology for MH/SUD services. The Virginia-specific analysis above constitutes the primary operational testing review for purposes of this comparative analysis. The following Cigna commercial book-of-business analysis is included as supplemental information and is intended to provide additional context regarding reimbursement patterns across a broader population.

Cigna 2025 Book of Business M/S Non-Facility In-Network Professional Services					
Provider Type	Provider Type Code	CPT Code	Mean Reimbursement	Medicare (or Cigna RBRVS) Reimbursement	% of Medicare
Internists MD	IM	99203	\$120.80	\$109.01	110.81%
		99213	\$85.11	\$88.95	95.69%
General Practice MD	GP	99203	\$101.88	\$109.01	93.46
		99213	\$75.74	\$88.95	85.15%
Family Practice MD	FP	99203	\$116.18	\$109.01	106.58%
		99213	\$87.61	\$88.95	98.49%
Mid-Levels	FA, NF, NG, NH, NS	99203	\$118.79	\$109.01	108.97%
		99213	\$82.80	\$88.95	93.09%
Cigna 2025 Book of Business MH/SUD Non-Facility In-Network Professional Services					
Psychiatrists	PY	99203	\$122.36	\$109.01	112.25%
		99213	\$74.84	\$88.95	84.14%
Child Psychiatrists	PY	99203*	\$137.82	\$109.01	126.43%
		99213	\$76.48	\$88.95	85.98%
Psychologists	PJ	90832	\$58.10	\$78.93	73.60%
		90791	\$130.82	\$166.91	78.38%
LCSW	LCSW	90832	\$50.75	\$78.93	64.30%
		90791	\$119.97	\$166.91	71.88%

*<10 visits

**<50 visits

Operational Testing Results

In its assessment, Cigna observed variation in reimbursement outcomes among provider types. Psychiatrist reimbursement levels generally fell within the range of physician reimbursement benchmarks evaluated, although variation was observed across provider types, codes and geographic markets. Psychologist and LCSW reimbursement levels differed from the selected mid-level provider comparisons. These outcome differences were further evaluated in conjunction with provider type, applicable Medicare reimbursement methodology, provider-specific reimbursement benchmarks, service code differences, scope-of-practice distinctions, contract negotiations, network needs, and other factors described in Steps Two and Three.

The selected CPT codes represent highly utilized services for the respective provider types and were selected to facilitate comparison of reimbursement outcomes using provider-specific services commonly furnished by M/S and MH/SUD practitioners. Because provider scope of practice, coding

conventions, and Medicare reimbursement rules differ among provider types, the selected codes should not be interpreted as clinically identical services. Accordingly, the comparisons were intended to evaluate operational reimbursement patterns for highly utilized provider-specific services rather than establish direct equivalency between the selected M/S and MH/SUD service codes.

For example, codes 90791 and 90832 are diagnostic and therapeutic services predominantly billed by MH/SUD providers and much less likely by M/S. While 99213 and 99203 are evaluation and management services that are much more likely to be billed by M/S rather than MH/SUD, albeit to a less discrepancy. Medicare establishes reimbursement for Clinical Social Worker services at 75% of the amount established for Clinical Psychologist services under the Medicare Physician Fee Schedule. Accordingly, comparisons involving LCSWs should be evaluated using the provider-specific Medicare benchmark applicable to the provider type being assessed. LCSWs are masters-level, non-prescribing providers, for which there is not a truly similar M/S provider type.

Cigna utilizes service codes 99213 (M/S) and 90791 (MH/SUD) based on guidance provided in the Department of Labor (DOL) Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) comparison framework, alongside review of internal claims data suggesting these codes were highly utilized. In addition to these codes, 99203 (M/S) and 90792 (MH/SUD) were also considered for inclusion due to the similarities in services offered compared to 99213/90791 and the review of internal claims data suggesting that these codes were also highly utilized. Per the self-compliance tool, service code 99213 was suggested for use amongst most M/S provider types and with MH/SUD Psychiatrists. Service code 90791 was recommended for inclusion in the self-compliance tool for Psychologists and LCSWs, as they are unable to bill E/M codes (99213) per their licensure.

Cigna also reviewed the operational application of the reimbursement NQTL, including access to standard reimbursement schedules, opportunities to request non-standard reimbursement, contracting review processes, approval requirements, and escalation procedures. The review did not further identify higher approval thresholds, additional documentation requirements, reduced opportunities for non-standard reimbursement, or more restrictive escalation requirements applicable to MH/SUD.

Based on the review of reimbursement outcomes, reimbursement methodologies, provider-specific benchmarks, contracting factors, exception processes, approval requirements, operational practices, and reimbursement policy implementation, Cigna concluded that the In-Network Outpatient Provider Reimbursement NQTL is designed and applied comparably and no more stringently to MH/SUD providers than to M/S providers. While variations in reimbursement outcomes were observed across certain provider types and services, Cigna's review did not identify a separate reimbursement methodology, higher evidentiary standard, more restrictive approval requirement, additional documentation burden, reduced access to exception consideration, or other operational practice that applied more stringently to MH/SUD providers than to similarly situated M/S providers. Accordingly, Cigna concludes that the In-Network Outpatient Provider Reimbursement NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

Step 6: Findings and conclusions.

See [45 CFR 146.137\(c\)\(6\)](#). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

- (1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;
- (2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;
- (3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;
- (4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and
- (5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the [FAQ 45](#) guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Base, Adjusted, and Final Rate conclusion:

Based on the written policies, reimbursement methodologies, contracting procedures, approval requirements and operational evidence described in Steps 1 through 5, Cigna determined that the

factors and evidentiary standards used to establish and negotiate in-network outpatient reimbursement are comparable for M/S and MH/SUD benefits within the applicable outpatient sub-classifications.

Specifically, reimbursement rates for both M/S and MH/SUD providers and facilities for outpatient services are the result of a negotiation between Cigna and each network provider. Each negotiation is handled on a case-by-case basis, and Cigna considers and applies these factors in each negotiation: the Federal or State Law, Provider Type, Medicare Baseline Rates, Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty), Geographic Market, Scope and Type of services, Medical Cost Budget, Utilization, and Competitive Insights. Whether for initial negotiation or renegotiation, Cigna's Network Provider reimbursement methodologies for M/S and MH/SUD Network Providers are based upon the same factors, evidentiary standards, approval requirements, and reimbursement methodologies described in Steps 2 through 4.

The operational data identified differences in reimbursement outcomes for certain provider types and service codes. Cigna did not treat those outcome differences as independently establishing either compliance or non-compliance. Instead, Cigna reviewed the underlying fee schedules, provider classifications, benchmark methodologies, negotiation records, exception processes, and approval controls to determine whether the differences resulted from an MH/SUD-specific factor, evidentiary standard, threshold, or approval requirement. The review did not identify such a differential requirement.

The same categories of factors, evidentiary standards, documentation expectations, and approval controls are available for consideration in initial negotiations and renegotiations involving M/S and MH/SUD providers and facilities. Individual reimbursement outcomes may differ because each negotiation reflects provider-specific and market-specific circumstances. Due to the highly variable nature of each negotiation, consistent outcomes are not always achieved. While comparable outcomes can be evidence of NQTL compliance, operational outcomes are not determinative of such compliance.

Although assessment of reimbursement rates and negotiated reimbursement outcomes may identify differences between certain M/S and MH/SUD provider types, specialties, geographic markets, service mixes, facility types, reimbursement methodologies, or provider-specific negotiations, differences in reimbursement outcomes alone do not establish a parity violation. Such differences must be evaluated in the context of the comparable factors, evidentiary standards, approval requirements, reimbursement methodologies, and negotiation processes applied to both MH/SUD and M/S benefits.

While the MH/SUD facility reimbursement percentage was lower than the M/S facility percentage in aggregate, both M/S and MH/SUD outpatient facility reimbursement substantially exceeded the CMS benchmark. The difference in aggregate percentage reimbursement does not indicate more stringent application of the reimbursement methodology to MH/SUD because the comparison reflects differences in service mix, APC distribution, provider mix, claim volume, facility type and negotiated provider-specific arrangements. The analysis did not identify a MH/SUD-specific factor, threshold, approval requirement or reimbursement methodology that would cause MH/SUD facility reimbursement to be limited more stringently than M/S facility reimbursement.

The processes, strategies, evidentiary standards, and factors used to set reimbursement are comparable and applied no more stringently to MH/SUD benefits. The lower reimbursement percentages reflected for psychologists and LCSWs should not be interpreted, standing alone, as evidence of a MHPAEA violation. The observed differences may be associated with provider type, service code, scope of practice, benchmark methodology, geography, contract structure, or other factors. The aggregate analysis was not designed to determine the extent to which any individual variable caused the observed reimbursement difference. Accordingly, the results were treated as an indicator requiring review of the underlying reimbursement processes rather than as evidence independently establishing compliance or noncompliance.

In addition, the broader reimbursement data does not show a uniform reduction for MH/SUD providers: psychiatrist and child psychiatrist reimbursement for certain E/M codes is at or above benchmark and, in some cases, exceeds comparable M/S reimbursement percentages. Accordingly, the observed reimbursement variation is better understood as the product of neutral reimbursement factors—provider type, licensure, scope of service, applicable benchmark, market dynamics, utilization, geography, and provider-specific negotiation—rather than evidence that the reimbursement NQTL is designed or applied more stringently to MH/SUD benefits.

Cigna additionally reviewed operational indicators related to member access, including provider contracting activity, network growth, provider participation, and network adequacy monitoring. The review did not identify evidence that reimbursement methodologies resulted in a material reduction in access to MH/SUD services or contributed to network adequacy deficiencies.

In evaluating provider participation outcomes, Cigna did not identify evidence indicating that reimbursement levels are creating material barriers to MH/SUD provider network participation.

Through September 2026, Cigna has received 967 applications from Virginia MH/SUD providers seeking network participation. Of those applicants, 633 were successfully contracted and 212 remain in process. Of the 122 applications that were declined, withdrawn, or otherwise discontinued, 9 identified reimbursement as a reason for the outcome.

In addition, of 683 Virginia MH/SUD provider terminations through September 2026, 26 identified reimbursement as a contributing factor. These data indicate that the majority of MH/SUD provider applications and terminations during the review period were not attributed to reimbursement-related reasons.

Lastly, as evidence of Cigna's success in establishing rates that help ensure the acquisition and retention of providers in its MH/SUD network, the facility rate renegotiation report for January 1, 2025 through December 31, 2025 documented 813 facility renegotiations, of which 725 negotiations were completed, 88 were discontinued due to the provider's non-responsiveness. Cigna has reviewed more than 9,137 reimbursement rates for outpatient-based fee schedules. The outpatient rate negotiation report for January 1, 2025 through December 31, 2025 includes a total of 5,626 completed/approved and 1,992 discontinued/incomplete due to provider non-response or decline.

In support of Cigna's contracting efforts and provider network retention, review of Virginia network adequacy reports, appointment accessibility monitoring, provider-to-member ratios, and provider

participation trends did not identify material access differences attributable to provider reimbursement methodologies. 2025 Network Adequacy monitoring shows no material gaps for outpatient professional or facility services. If reimbursement methodology were operating as a material barrier to MH/SUD provider participation, Cigna would reasonably expect to observe reimbursement-related recruitment failures, provider attrition, or network adequacy deficiencies. Review of provider contracting, provider terminations, and network adequacy monitoring did not identify those patterns.

The operational data reviewed in Step 5 were evaluated within the context of their respective methodological limitations, including differences in provider mix, contract terms, utilization, geography, service type, reimbursement methodology, and available data volume. Cigna therefore considered the operational outcomes together with the written reimbursement methodology, contracting documentation, negotiation records, approval requirements, and other available evidence when reaching its conclusions.

Cigna identified certain administrative differences between the M/S and MH/SUD reimbursement frameworks, including differences in terminology, fee schedule structures, and internal contracting processes. Based on the analyses described in Steps 2 through 4, Cigna concluded that these differences are administrative and operational in nature and do not impose additional reimbursement requirements, approval thresholds, evidentiary standards, or contracting restrictions on MH/SUD providers.

The analyses described in Steps 2 through 5 identified differences between practitioner and facility reimbursement methodologies, including differences in the underlying reimbursement benchmarks, payment methodologies, and reimbursement structures. Cigna concluded that these differences reflect operational distinctions between provider types and reimbursement methodologies and are applied comparably to both MH/SUD and M/S providers within the applicable outpatient classifications.

In conclusion, the full comparative analysis supports Cigna's determination that the in-network outpatient provider reimbursement NQTL is designed and applied comparably, and no more stringently, for MH/SUD benefits than for M/S benefits. The observed reimbursement variation, including lower percentages for certain psychologist and LCSW psychotherapy and diagnostic evaluation codes, does not establish a parity violation because those outcomes are explained by neutral provider-type, licensure, scope-of-service, benchmark, geographic, utilization, market, and provider-specific negotiation factors rather than by a MH/SUD-specific reimbursement limitation. Cigna will continue to monitor provider reimbursement methodology, contracting outcomes, provider participation, and network adequacy indicators to confirm that the underlying processes, strategies, evidentiary standards, and factors remain comparable in operation.

Accordingly, based on its review of the plan language, written policies, reimbursement methodologies, operational testing, provider contracting activity, and access-related indicators, Cigna concludes that the processes, strategies, evidentiary standards, and other factors used to determine reimbursement rates for MH/SUD in-network outpatient services are comparable to, and applied no more stringently than, those used to determine reimbursement rates for M/S in-network outpatient services in the same benefit classifications.

Based on the written policies, reimbursement methodologies, validated operational testing,

provider contracting activity, and access-related indicators described in this analysis, Cigna concludes that the processes, strategies, evidentiary standards, and other factors used to determine reimbursement for MH/SUD in-network outpatient services are comparable to, and applied no more stringently than, those used for M/S in-network outpatient services within the same subclassifications. This conclusion is subject to completion and documentation of the data validations and targeted follow-up identified in Step 5.

This version of the analysis was drafted and performed in 2026 based upon Cigna's and Virginia 2025 book-of-business data, by members of the legal, compliance, and various business teams, including the following individuals:

Mental Health Parity Legal Team including:

Managing Counsel;
Associate Senior Counsel; and
Legal Compliance Senior Advisor

Mental Health Parity Compliance team including:

Legal Compliance Senior Manager;
Legal Compliance Senior Advisor

M/S and MH/SUD subject matter experts including:

Program Management Senior Manager;
Provider Contracting Senior Advisor;
Provider Contracting Senior Director