

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 Inpatient 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 comprehensive analysis addresses the In-Network Inpatient Provider Reimbursement NQTL applied to mental health/substance use disorder (“MH/SUD”) and/or medical/surgical (“M/S”) services for the inpatient 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 inpatient 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 Inpatient 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 M.C. Dean, Inc. 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 inpatient 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 Inpatient Provider Reimbursement NQTL is excerpted from M.C. Dean, Inc. language and states as follows:

M.C. Dean, Inc. Plan Language
Mental Health Parity and Addiction Equity Act The Certificate is amended as stated below:

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

Visit Limits:

Any health care service billed with a Mental Health or Substance Use Disorder diagnosis, will not incur a visit limit, including but not limited to genetic counseling¹

Charges

The term charges means the actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.²

Allowable Expense

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services³

Participating Provider

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.⁴

Description of the NQTL:

The In-Network (INN) Inpatient Provider Reimbursement NQTL consists of the processes, strategies and methodologies Cigna utilizes to establish, negotiate, approve and apply network reimbursement rates, for participating inpatient providers and facilities. It includes the selection

1 M.C. Dean, Inc. Plan Booklet pg. 8 of 90

2 M.C. Dean, Inc. Plan Booklet pg. 76 of 90

3 M.C. Dean, Inc. Plan Booklet pgs. 56-57 of 90

4 M.C. Dean, Inc. Plan Booklet pg. 83 of 90

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 Inpatient classification. 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 Inpatient M/S facilities as shown in the List of Services Subject to the NQTL may be reimbursed based on Diagnosis Related Group (“DRG”) which is a patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital, Per Diem which is a per day, all-inclusive reimbursement rate for all covered services provided on that day, and Percent of Charge.
INN Inpatient MH/SUD facilities as shown in the List of Services Subject to the NQTL are reimbursed based on Per Diems, which are a per day, all-inclusive reimbursement rate for all covered services provided on that day, and Percent of Charge.
- Professional services rendered by physicians or other practitioners during an inpatient stay may be billed separately and reimbursed under the applicable professional fee schedule or provider-specific negotiated arrangement. Where a facility contract expressly includes specified professional services within an all-inclusive facility payment, those services are not separately reimbursed. Cigna applies the applicable contractual arrangement and claim-billing requirements without regard to whether the underlying covered service is classified as MH/SUD or M/S.

Other Payment Models:

Cigna does not utilize capitation, salary-based reimbursement, bundled compensations arrangements, or other alternative payment models in its reimbursement of M/S or MH/SUD INN Inpatient 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. 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.
2. 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).
2. 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).

3. 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.
4. 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.
5. 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.
6. Transparency Data: Publicly available or disclosed pricing and reimbursement information made available under federal transparency requirements, including the No Surprises Act and related transparency provisions. This data may include negotiated rates, allowed amounts, reimbursement benchmarks or other pricing information disclosed pursuant to applicable federal transparency requirements.

Supporting Documents:

Document/Policy Name	Description
M.C. Dean, Inc. 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	Sets 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.

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) Inpatient 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 Inpatient benefit classification. The list 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 Inpatient classification?	Yes Hospice - IP Other HC Facility Inpatient Hospital Inpatient Hospital Physician's Visit/Consultation Inpatient Preventive Inpatient Professional Services Inpatient Surgery	Yes Acute Inpatient (Mental Health and Substance Use) Acute Inpatient Detoxification MH/SUD Residential Treatment

	Inpatient Services at Other Health Care Facilities (Long Term Acute Care – Medical, Skilled Nursing Facility and Rehab – Medical)	
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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) Inpatient Provider Reimbursement. In designing and applying the In-Network Inpatient Reimbursement NQTL, Cigna

did not consider and subsequently reject any additional factors. 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, services, geographic market, reimbursement methodology, and negotiation.

No discretionary factor is assigned a predetermined numerical weight. The relative significance of a factor depends upon the facts and circumstances associated with the provider, facility, services, geographic market, and negotiation under review.

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/ Sub-classification	Factors	Sources for Each Factor
In-Network Inpatient	1. Federal and State Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty which determines the applicable type of reimbursement. 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 Law 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. Facility: Medicare Inpatient Prospective Payment System (IPPS) Practitioner: 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. 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

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
		PFS. i.e., market rate and payment type for provider type and/or specialty 6. Types of Service are identified by CPT, HCPCS and Revenue 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 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 establishing the factors used to determine In-Network (INN) Inpatient Provider Reimbursement, Cigna considers the following sources and **evidentiary standards**:

Benefit Classification/ Sub-classification	Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
In Network Inpatient	1. Federal and State Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates	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	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

	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	framework unless a documented network, market, service, or contracting consideration supports a different rate. 3. Medicare baseline rates: Facility: Diagnosis Related Group (“DRG”): Patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. (citation: <u>CMS.gov</u>). Applicable to Facility Inpatient benefit classifications. For DRG reimbursement, weighting is not calculated within the contract or at the time of contract rate negotiation but instead occurs at the time of payment as DRG reimbursement is dependent on a variety of variable factors as indicated on the claim form, such as patient age and diagnosis. Cigna utilizes CMS grouping software (Optum) that takes the information from the claim and “groups it” into the correct DRG. That DRG information is then used to calculate the reimbursement, based on the applicable reimbursement terms contained in the provider agreement. Cigna’s DRG base rates are calculated using the factors defined in Step 1. The base rates for DRG are listed in the contract. The base rate is then multiplied by the CMS DRG weighting to determine reimbursement.	practitioners vs. facilities). 3. Facility: Medicare Inpatient Prospective Payment System (IPPS) Practitioner: 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).
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		• 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 may utilize Medicare pricing information as a benchmark when valuating proposed reimbursement arrangements. Standard reimbursement schedules may be developed using Medicare reimbursement as a benchmark and may vary by provider type, specialty, service category, and geographic market. 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: $[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice Expense RVU} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})] = \text{Geographically Adjusted RVU Total} \times \text{Conversion Factor (CF)} = \text{Cigna RBRVS geographically adjusted fee Reimbursement}$	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, HCPCS and Revenue 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 Data (No Surprises Act Section 114: 42 USC 300gg et
		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 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,	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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		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: • 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 -	
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		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 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	
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		quality concern or reimbursement consequence. Consideration is based on substantiation, severity, frequency, recency, corrective action status, and other available quality information 5. Facility: Geographic market (i.e., market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon the CMS Hospital wage index. Practitioner: 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 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	
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		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 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	
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		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 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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Cigna uses objective, reliable, and verifiable information in designing and applying the In-Network Inpatient 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, which are uniformly applicable to both M/S and MH/SUD providers and facilities.

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 Inpatient classification, 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.

During reimbursement review, Cigna first determines whether applicable federal or state legal requirements govern the reimbursement arrangement. Next, Cigna identifies the provider type, specialty, service category, and applicable reimbursement methodology. Cigna then evaluates the applicable reimbursement benchmark or methodology, geographic market considerations, scope and type of services, market dynamics, utilization information, competitive information when available, and medical cost budget considerations. The relative significance of any factor depends on the provider, services, market, reimbursement methodology, and negotiation under review.

For inpatient facility reimbursement, CMS IPPS methodologies and benchmarks, including DRGs, wage indices, and other CMS payment components, may be used where applicable to the provider type, payment methodology, and contractual arrangement. Depending upon the provider and contract structure, reimbursement may be based upon DRGs, per diem arrangements, percent of billed charges, or other contractually specified reimbursement methodologies.

Rates for inpatient practitioner claims utilize Medicare Physician Fee Schedule methodologies and benchmarks as applicable to the reimbursement methodology and contractual arrangement. The Medicare Physician Fee Schedule (PFS) relies on:

- 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);

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

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

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).

The same approval framework applies to both MH/SUD and M/S provider reimbursement reviews.

Base Rates:

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.

Standard reimbursement rates are reimbursement rates that a provider accepts without contract negotiation. Standard reimbursement rates for M/S and MH/SUD inpatient 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.

The following factors are considered in all standard reimbursement rates for both M/S and MH/SUD 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

For base rates, Cigna applies the identified factors when developing the the initial reimbursement methodology and rate proposal offered to a provider or facility. This evaluation occurs before any provider specific negotiations and establishes the starting point for the contracting process.

Adjusted Rates:

Non-Standard reimbursement rates are fee schedules developed based upon a negotiation request from the provider. 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

Federal and state legal requirements are evaluated first and, where applicable, supersede discretionary contracting considerations. When a reimbursement methodology, payment amount, or contracting requirement is mandated by law, that requirement is implemented according to the applicable legal standard.

Adjusted Rates are evaluated using the same factors and evidentiary standards used for Base Rates, although the relative significance of individual factors may differ depending upon the provider-specific circumstances underlying the negotiation request.

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 can 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 counteroffer)
- 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 counteroffer, 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. The number of Network Providers (Individual, Group or Facility) joining or already part of the network does not factor into initial rate offerings.

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:

Cigna does not use third-party vendors to establish, negotiate, approve, or apply reimbursement rates for in-network inpatient services. In addition, Cigna does not apply a reimbursement reduction based solely on a practitioner's status as a non-physician practitioner.

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies. Cigna is providing the below Provider Reimbursement policies used in the application of the Provider Reimbursement NQTL to demonstrate comparability and consistency. As described in policy *OPS-18 Policy and Procedure Maintenance, Review and Approval Process*, these Cigna policies were developed and reviewed according to URAC and NCQA standards, and regulatory requirements.

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.

For inpatient facility reimbursement, the In-Network Reimbursement Methodology document governs the development and application of DRG, Per Diem, Percent-of-Charge, and other facility reimbursement methodologies for both MH/SUD and M/S providers. As written, the same categories of factors, evidentiary standards, contracting considerations, and approval processes identified in Step 2 are available for consideration for both MH/SUD and M/S facility reimbursement determinations.

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 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.
	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 schedule 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.

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 and MH/SUD reimbursement policies use different terminology and administrative structures. For example, the M/S policy references Cigna-Controlled fee schedules, while the MH/SUD policy references Standard Fee Schedules. These administrative differences do not create a more stringent reimbursement framework for MH/SUD providers because both policies establish reimbursement methodologies based upon Medicare-derived benchmarks, regional or market considerations, provider type, and applicable reimbursement methodologies. Both policies permit reimbursement arrangements that differ from the standard fee schedule and utilize approval processes intended to support network access and financial oversight. Accordingly, the identified differences are administrative in nature and do not impose additional reimbursement restrictions or requirements on MH/SUD providers.

As written, neither policy requires MH/SUD providers to satisfy additional reimbursement criteria, documentation requirements, approval levels, network need thresholds, or quality standards that are not similarly available for consideration with respect to M/S providers. Both policies utilize Medicare-based reimbursement benchmarks, regional or market-specific fee schedules, and provider-type distinctions to establish standard reimbursement arrangements.

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.

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) reimbursement levels to meet varying needs of the local network.	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.
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 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 NQTL'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 Inpatient 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.

Negotiated Contracts:

Data Methodology:

Cigna reviewed all Virginia inpatient facility contracting matters completed during calendar year 2025 for which a standard or negotiated reimbursement rate was accepted. The review included one M/S facility contract and four MH/SUD facility contract instances. No inpatient practitioner contracts met the selection criteria. 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 inpatient 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 inpatient contract instances reviewed for the applicable benefit category. The reviewed population consisted of one M/S and four MH/SUD facility contract instances. Because of the limited population size, the resulting percentages are descriptive and were not treated as statistically reliable measures of comparative stringency. Cigna therefore supplemented the aggregate results with an individual review of each contract’s initial rate, negotiation request, factors considered, supporting documentation, approval path, and final outcome.

Outcome data:

	Total Inpatient Contract Instances Reviewed	
	M/S	MH/SUD ⁵
	Inpatient	Inpatient
Facility	1	4
Practitioner	0	0
	Number Accepting Initial Standard Rate	
	M/S	MH/SUD
	Inpatient	Inpatient
Facility	0	1
Practitioner	0	0
	Percentage Accepting Initial Standard Rate	
	M/S	MH/SUD
	Inpatient	Inpatient

⁵ The 2025 MH/SUD source population included contracts that could cover both inpatient and outpatient services. For this analysis, each contract was classified at the applicable benefit-classification level. Four MH/SUD contract instances included inpatient services: three involved negotiated rates and one accepted the standard rate. Accordingly, classification-level counts may exceed the number of unique contracts in the broader source population.

Facility	0%	25%
Practitioner	n/a	n/a
	Number Accepting Negotiated Rate	
	M/S	MH/SUD
	Inpatient	Inpatient
Facility	1	3
Practitioner	0	0
	Percentage Accepting Negotiated Rate	
	M/S	MH/SUD
	Inpatient	Inpatient
Facility	100%	75%
Practitioner	n/a	n/a

The Virginia inpatient contracting population was small, consisting of one M/S facility contract and four MH/SUD facility contracts. Accordingly, the acceptance percentages are descriptive and are not treated as statistically stable indicators of comparative stringency. Cigna therefore evaluated the available inpatient 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.

Cigna’s individual review of the one M/S and four MH/SUD inpatient 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 M/S or MH/SUD 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 contracts in the factors considered, the information required, or the approval process applied.

Reimbursement Table B – Inpatient Facility Services:

Data Methodology: Reimbursement Table B evaluates facility services rendered in an inpatient 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 used to identify the inpatient settings applicable to each benefit category. The analysis does not include institutional facility reimbursement under DRG, per diem, percent-of-charge, or other facility payment arrangements.

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. Facility claims are assigned to the In-Network Inpatient classification using the POS code reported on the claim. The applicable POS codes are identified below.

MH/SUD Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as in-network; and

- facility claims reported with one of the following POS codes:
 - Inpatient Hospital (POS 21);
 - Inpatient Psychiatric Facility (POS 51); or
 - Residential Substance Abuse Treatment Facility (POS 55).

M/S Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as in-network; and
- facility claims reported with one of the following POS codes:
 - Inpatient Hospital (POS 21);
 - Skilled Nursing Facility (POS 31); or
 - Comprehensive Inpatient Rehabilitation Facility (POS 61).

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 inpatient 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/paid amount—confirm the actual field used] 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.

Outcome data:

Reimbursement Table B

MH/SUD

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
In-Network Inpatient	Inpatient Hospital (POS 21)	Facility	H2013	\$1,200.00	\$664.00
In-Network Inpatient	Inpatient Hospital (POS 21)	Facility	H0010	\$4,964.58	\$1,020.71

M/S:

CLASSIFICATION	PROVIDER TYPE	TYPE	REVENUE OR PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
In-Network Inpatient	Comprehensive IP Rehab	Facility	420	\$5.82	\$2.88

In-Network Inpatient	Comprehensive IP Rehab	Facility	430	\$5.80	\$2.82
In-Network Inpatient	Comprehensive IP Rehab	Facility	440	\$6.03	\$2.97
In-Network Inpatient	Comprehensive IP Rehab	Facility	128	\$1,180.96	\$568.74
In-Network Inpatient	Comprehensive IP Rehab	Facility	300	\$31.29	\$15.53
In-Network Inpatient	Comprehensive IP Rehab	Facility	148	\$1,175.00	\$636.08
In-Network Inpatient	Comprehensive IP Rehab	Facility	250	\$1,546.19	\$749.43
In-Network Inpatient	Comprehensive IP Rehab	Facility	410	\$155.40	\$78.39
In-Network Inpatient	Comprehensive IP Rehab	Facility	138	\$1,240.00	\$583.39
In-Network Inpatient	Comprehensive IP Rehab	Facility	270	\$15.00	\$7.73
In-Network Inpatient	Inpatient Hospital	Facility	77386	\$6,186.00	\$1,756.77
In-Network Inpatient	Inpatient Hospital	Facility	86900	\$213.96	\$26.28
In-Network Inpatient	Inpatient Hospital	Facility	86901	\$154.38	\$23.61
In-Network Inpatient	Inpatient Hospital	Facility	20930	\$7,844.00	\$2,468.62
In-Network Inpatient	Inpatient Hospital	Facility	20936	\$7,844.00	\$2,468.62
In-Network Inpatient	Inpatient Hospital	Facility	22551	\$7,844.00	\$2,468.62
In-Network Inpatient	Inpatient Hospital	Facility	22552	\$7,844.00	\$2,468.62
In-Network Inpatient	Inpatient Hospital	Facility	22845	\$7,844.00	\$2,468.62
In-Network Inpatient	Inpatient Hospital	Facility	22853	\$15,688.00	\$4,937.25
In-Network Inpatient	Inpatient Hospital	Facility	36415	\$76.32	\$2,478.22
In-Network Inpatient	Skilled Nursing Facility	Facility	420	\$76.69	\$26.10
In-Network Inpatient	Skilled Nursing Facility	Facility	430	\$77.03	\$24.34
In-Network Inpatient	Skilled Nursing Facility	Facility	191	\$408.79	\$329.52
In-Network Inpatient	Skilled Nursing Facility	Facility	193	\$507.00	\$263.35
In-Network Inpatient	Skilled Nursing Facility	Facility	192	\$408.48	\$260.55
In-Network Inpatient	Skilled Nursing Facility	Facility	440	\$161.04	\$40.35

In-Network Inpatient	Skilled Nursing Facility	Facility	940	\$25.96	\$13.59
In-Network Inpatient	Skilled Nursing Facility	Facility	120	\$400.00	\$280.00
In-Network Inpatient	Skilled Nursing Facility	Facility	250	\$443.33	\$60.53
In-Network Inpatient	Skilled Nursing Facility	Facility	424	\$191.68	\$63.59

The reimbursement outcome data reflects Virginia fully insured claims experience for calendar year 2025 and use 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 setting. Because the selection was performed within provider-setting categories, less than 10 total rows may appear in each benefit group.

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

The analysis applied identical claims-selection criteria and the same average-reimbursement formula to M/S and MH/SUD claims. For each included code, total allowed amounts were divided by total reported service units. The network-status criteria, Virginia fully insured population, calendar year 2025 measurement period, and calculation methodology were applied uniformly.

The only population difference was the use of POS codes corresponding to the inpatient settings applicable to each benefit category. MH/SUD included POS 21, 51, and 55; M/S included POS 21, 31, and 61. These setting-specific distinctions do not impose a different reimbursement standard, threshold, formula, or claims-processing requirement on MH/SUD benefits.

For MH/SUD, the average allowed amount was \$664.00 per unit for H2013 and \$1,020.71 per unit for H0010, representing 55.33% and 20.56% of average billed amounts, respectively. M/S average allowed amounts varied by code and setting: \$2.82–\$749.43 for Comprehensive Inpatient Rehabilitation Facilities, \$13.59–\$329.52 for Skilled Nursing Facilities, and \$23.61–\$4,937.25 for Inpatient Hospitals. The variation within and between benefit categories reflects differences in service codes, provider settings, unit definitions, service mix, billing practices, and negotiated contractual terms—not differential application of the reimbursement NQTL.

The reported M/S and MH/SUD amounts are not suitable for direct code-level comparison because the populations contain different codes, facility types, and service compositions. The billed-to-allowed relationship likewise is not an independent parity measure because billed charges are provider-established and the results do not control for provider, contract, geography, specialty, modifiers, service volume, fee schedule, benchmark year, or other payment characteristics. Accordingly, differences in the reported amounts do not demonstrate greater stringency for MH/SUD benefits.

Cigna evaluated these results together with the governing reimbursement methodologies, contracting outcomes, negotiation records, approval requirements, and other operational evidence. The totality of the evidence demonstrates that Cigna used comparable claims-selection

criteria, calculation methods, contracting processes, and reimbursement controls for M/S and MH/SUD inpatient facility services. No separate formula, additional threshold, reduced reimbursement factor, heightened documentation requirement, or more restrictive approval standard applied to MH/SUD claims. Cigna therefore concludes that the In-Network Inpatient Provider Reimbursement NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

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

Reimbursement Rates; inpatient facility services

Cigna compared reimbursement rates for in-network M/S and MH/SUD inpatient facility services across Cigna's commercial book of business utilizing a subset of 2025 in-network facility claims selected based on DRG's.

For the selected services, Cigna applied a common CMS-based pricing methodology to calculate a modeled CMS reimbursement amount for each claim. Cigna then compared the Cigna allowed amount with the corresponding modeled CMS amount to evaluate reimbursement for the selected M/S and MH/SUD inpatient facility services on a consistent basis.

The M/S and MH/SUD services included in the analysis are not clinically identical and were not selected as matched or clinically equivalent services. Accordingly, the analysis does not compare reimbursement for identical services. Rather, the modeled CMS amounts provide a common benchmark for evaluating Cigna's allowed amounts across the selected M/S and MH/SUD inpatient facility claims.

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- M/S

- 7500807 – 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.

For the selected inpatient facility claims, aggregate Cigna allowed amounts were divided by the corresponding aggregate modeled CMS amounts. This calculation produced an aggregate to allowed to modeled-CMS ratio of 181% for the selected M/S claims and 173% for the selected MH/SUD claims an eight-percentage-point difference.

Cigna evaluated this difference as a descriptive outcome and did not apply a predetermined numerical threshold to determine materiality. The analysis did not adjust for differences in DRG distribution, facility mix, geographic distribution, contractual reimbursement methodology, length of stay, or claim volume. Accordingly, the aggregate ratios do not constitute a risk-adjusted or matched comparison of clinically equivalent services and were not treated, standing alone, as establishing either comparability or noncomparability in the application of the reimbursement NQTL. Cigna evaluated the results together with the contracting, negotiation, documentation, and approval evidence described above in assessing whether the reimbursement processes were comparable and applied no more stringently to MH/SUD benefits than to M/S benefits.

Facility Reimbursement Details							Cigna		CMS		
Type	Category	Cigna \$	CMS \$	CMS	Claim	Days/Visits	\$ Per	\$ Per	\$ Per	\$ Per	ALOS

of Claim		Allowed	Allowed	%	Count		Claim	Day	Claim	Day	
IP	M/S	\$807,614,748	\$446,013,154	181%	48,873	152,723	\$16,525	\$5,288	\$9,126	\$2,920	3.1
IP	MH/SUD	\$90,065,335	\$52,075,754	173%	3,934	67,758	\$22,894	\$1,329	\$13,237	\$769	17.2

This supplemental facility analysis uses Cigna commercial book-of-business data and is not limited to Virginia fully insured claims. Accordingly, its results are considered supplemental and are not substituted for the Virginia-specific operational evidence.

Reimbursement Rates; inpatient practitioner services

Professional services rendered during an inpatient stay may be separately billed and reimbursed under the applicable professional fee schedule or provider-specific negotiated arrangement. The professional claims analysis above evaluates such separately billed services based on the place of service reported on the claim. Where a facility agreement expressly includes specified professional services within an all-inclusive facility reimbursement arrangement, those services are not separately reimbursed and are reflected in the applicable facility payment. Accordingly, the professional and facility analyses are presented separately and should not be combined.

Cigna reviewed available Virginia inpatient access information relevant to the potential operational effect of provider reimbursement, including network adequacy results, provider recruitment and contracting activity and provider terminations. The reviewed information did not identify a material difference in access to inpatient MH/SUD benefits compared with inpatient M/S benefits that the available records attributed to the reimbursement processes evaluated in this analysis. These access indicators were considered together with the contracting and reimbursement outcomes and were not treated as independently establishing compliance or excluding other possible causes of access variation.

Based on the data evaluated, Cigna did not identify a material difference in inpatient access attributable to the reimbursement NQTL. Accordingly, no reimbursement-specific corrective action was triggered. Cigna continues to review the identified operational indicators through its established monitoring and contracting processes.

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 analyses described in Steps 1 through 5, including the governing reimbursement policies and methodologies, factors and evidentiary standards, contracting and approval requirements, negotiation records, and available operational data, Cigna determined that the processes, strategies, evidentiary standards, factors, approval requirements, and reimbursement methodologies used to determine in-network inpatient reimbursement for MH/SUD services are comparable to, and applied no more stringently than, those used for M/S services in the same inpatient classification. For both M/S and MH/SUD reimbursement Cigna establishes an initial reimbursement methodology and rate proposal and, when applicable, evaluates a request for different reimbursement terms through negotiation. Federal and state legal requirements are applied where applicable. Other factors – including, provider type, and specialty, Medicare based benchmarks, market dynamics geographic market, scope and type of services, medical cost budget, utilization, and available competitive information - are considered to the extent relevant to the particular provider, facility, service, reimbursement methodology, market, and contracting circumstances.

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 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 the assessment of reimbursement outcomes identified differences in observed reimbursement results between MH/SUD and M/S providers, differences in end-state reimbursement rates alone do not establish a parity violation where those outcomes result from comparable reimbursement processes, factors, evidentiary standards, contracting considerations, and approval requirements.

Cigna has taken proactive steps to evaluate and maintain the comparability of reimbursement methodologies, reimbursement-related contracting standards, evidentiary standards, and approval processes applicable to MH/SUD and M/S providers.

As evidence of Cigna's success in establishing rates that help ensure the acquisition and retention of providers in its MH/SUD network, the national MH/SUD 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 reviewed available Virginia inpatient network adequacy, contracting, termination, recruitment, and provider-participation information as supplemental indicators. The reviewed information did not identify a material inpatient access concern that the available records attributed to the reimbursement processes evaluated in this analysis. These indicators are not treated as independently establishing parity compliance or as excluding other potential causes of network-access variation.

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 inpatient classification.

Based on the written policies, reimbursement methodologies, decision factors, evidentiary standards, approval requirements, and available operational information described in this analysis, Cigna determined that the processes used to establish and negotiate in-network inpatient reimbursement for MH/SUD benefits are comparable to, and are not applied more stringently than, the processes used for M/S benefits in the inpatient classification. Aggregate reimbursement outcomes were considered as supplemental operational information and were not treated as a standalone parity standard. This conclusion is subject to the data limitations and scope parameters described in Step 5.

This version of the analysis was drafted and performed in 2026 based upon Virginia and Cigna's 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;