NQTL: Participating Provider Reimbursement – Professionals

Benefit classifications to which NQTL applies: ✔ **INN IP** ✔ **INN OV** ✔ **INN OP AO** ✔ **Emergency**

A detailed analytical framework is not provided for the Prescription Drug benefit classifications since there is not a division between M/S and MH/SUD with regard to Participating Provider Reimbursement.

Plan Terms and/or Description of NQTL:
This NQTL is implemented by [redacted].

M/S services NQTL applies to:	**MH/SUD services NQTL applies to:**
Applies to all M/S benefits delivered in-network	Applies to all MH/SUD benefits delivered in-network

Factors:
Factors used in designing the NQTL

The following factors are used to establish the [redacted] which is the preferred fee schedule for MH/SUD and M/S network providers. [redacted]

Provider type: Provider type refers to the provider's licensure type (e.g., MD, DO, LCSW, RN).

Service type: Service type is a factor that bases reimbursement on the billing codes submitted by a provider (e.g., initial assessments are generally reimbursed at a higher rate than follow-up appointments). Service types are identified by CPT and HCPC codes.

Index rates: The Resource Based Relative Value System (RBRVS) payment methodology developed by the Centers for Medicare and Medicaid Services (CMS) is used as a benchmark in developing [redacted] and contracting with providers for the Negotiated Charges. CMS, in consultation with the American Medical Association, assigns Relative Value Units (RVUs) to service codes to reflect the physician or other provider work involved, practice expense and liability insurance each service code entails. CMS applies a conversion factor to the RVU and an adjustment for the geographic area to calculate the resulting RBRVS rate. Where there is no RBRVS rate, [redacted]

Market dynamics: The local networks establish [redacted]

When contracting with a given provider, additional factors may enter into consideration:

Unit Cost Trend Target: [redacted]

[redacted]

[redacted]

Provider leverage: AKA bargaining power. This is generally a function of the relative scarcity of the provider's specialty or area of focus, member needs for that specialty/focus, whether the provider group is a large system or practice group that includes numerous specialties, plan sponsor demand, the provider's participation with other payors, and any other factors that dictate a provider's ability to negotiate a rate higher [redacted], as well as the number of members the carrier is able to drive to the provider.

Sources:
Processes, strategies and/or evidentiary standards used to design and apply the NQTL

Strategy: Achieve total health care cost rates that are competitive with the total health care cost rates for similar products issued by third parties in the market so as to achieve premium pricing required to compete effectively and drive membership growth.

Process:

[redacted]

[redacted]

Evidentiary Standards: The evidentiary standard for index rates used in setting [redacted] is the CMS Resource Based Relative Value Scale (RBRVS) payment system. [redacted]

Comparability and Stringency Analysis:
Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation

[redacted]

AMFS (Office-Based Providers):

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

(2) In contracting with providers, the Plan also uses comparable factors, strategies, processes and evidentiary standards for MH/SUD providers and M/S providers, both as written and in operation. The key factors are the Unit Cost Trend Target and Provider Leverage. The fact that the Trend Target for standalone MH/SUD providers is set at the national level whereas the trend target for M/S providers is at the local market level does not render the process incomparable; [redacted]

[redacted] According to DOL, HHS and Treasury, "[u]nder this analysis, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity" (see FAQs part 45, April 2, 2021, at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf).

Another indicator that participating provider reimbursement does not have a disparate impact on MH/SUD benefits is whether the MH/SUD network of participating providers is adequate. When a network has an adequate number of providers (determined by whether it meets the applicable network adequacy standards), it can be assumed that reimbursement is adequate. Aetna's MH/SUD network of non-facility providers met Illinois network adequacy standards in 2022.

Summary of Conclusions:

In summary, the factors, processes, strategies, evidentiary standards, and other factors used to reimburse MH/SUD network providers are comparable to, and are applied no more stringently than, for M/S providers, both as written and in operation.

Referenced Policies and Documents:

- [redacted]

NQTL: Participating Reimbursement – Facilities

Benefit classifications to which NQTL applies: ✔ INN IP ✔ INN OV ✔ INN OP AO ✔ Emergency

Plan Terms and/or Description of NQTL:
This NQTL is implemented by the plan's definition of Negotiated Charge, which is the amount a network provider has agreed to accept or that we have agreed to pay them or a third-party vendor (including any administrative fee in the amount paid).

M/S services NQTL applies to:	MH/SUD services NQTL applies to:
Applies to all M/S benefits delivered in-network	Applies to all MH/SUD benefits delivered in-network

Factors:
Factors used in designing the NQTL

The factors on which Negotiated Charges are based are:

Provider type: Type of facility (inpatient hospital, ambulatory surgery center, etc.)

Scope and complexity of services: range of practice specialties, levels of care and settings offered by the facility

Service type: Service type is a factor that bases reimbursement on the billing codes submitted by a provider (e.g., initial assessments are generally reimbursed at a higher rate than follow-up appointments). Service types are identified by CPT and HCPC codes. For facility-based providers, type of service also refers to inpatient or outpatient.

Index rates: Medicare DRGs and Medicare RVRBS rates

Competitive data: Refers to what competitors pay the facility for the same services, to the extent that can be determined from information publicly available through state and federal All Payor Claims Databases. [redacted]

Market dynamics: The local networks [redacted]

When contracting with a given provider, additional factors may enter into consideration:

Unit Cost Trend Target: [redacted]

[redacted]

Provider leverage: AKA bargaining power. [redacted]

Sources:
Processes, strategies and/or evidentiary standards used to design and apply the NQTL

Strategy: Achieve total health care cost rates that are competitive with the total health care cost rates for similar products issued by third parties in the market so as to achieve premium pricing required to compete effectively and drive membership growth.

Process: [redacted]

[redacted]

Evidentiary Standards
Index rates are referred to when developing rates for services that are paid according to a Medicare DRG or fee for service (AMFS) methodology.

Comparability and Stringency Analysis:
Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation

The factors, strategy, processes and evidentiary standards for determining reimbursement for MH/SUD facility-based providers are comparable to M/S facility-based providers both as written and in operation, inasmuch as the Negotiated Charges are ultimately subject to individualized negotiations between Aetna and the facility.

Notwithstanding the comparable processes, most MH/SUD facilities are paid on a *per diem* basis, whereas M/S facilities are paid by a wide variety of reimbursement methodologies including DRGs, *per diem*, percent of Medicare and percent of billed charges. This difference is due to the fact that Medicare

DRGs are not available for MH/SUD services. Also, the structures and scope of services of MH/SUD facilities are simpler than those of M/S facilities which often have multiple specialties and locations and provide a wide range of service types; multiple reimbursement methodologies are therefore more common within a single M/S facility contract.

[redacted]

AMFS (Facility-Based Providers):

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted] According to DOL, HHS and Treasury, "[u]nder this analysis, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity" (see FAQs part 45, April 2, 2021, at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf).

Another indicator that participating provider reimbursement does not have a disparate impact on MH/SUD benefits is whether the MH/SUD network of participating providers is adequate. When a network has an adequate number of providers (determined by whether it meets the applicable network adequacy standards), it can be assumed that reimbursement is adequate. Aetna's MH/SUD network of facilities met Illinois network adequacy standards in 2022.

Summary of Conclusions:

In summary, the factors, processes, strategies, evidentiary standards, and other factors used to reimburse MH/SUD network facilities are comparable to, and are applied no more stringently than, for M/S providers, both as written and in operation.

Referenced Policies and Documents:

[redacted]