### NQTL: Participating Provider Reimbursement – Professionals

<table>
<thead>
<tr>
<th>Benefit classifications to which NQTL applies:</th>
<th>✓ INN IP</th>
<th>✓ INN OV</th>
<th>✓ INN OP AO</th>
<th>✓ Emergency</th>
</tr>
</thead>
</table>

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 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:

Applies to all M/S benefits delivered in-network

### MH/SUD services NQTL applies to:

Applies to all MH/SUD benefits delivered in-network

### Factors:

**Factors used in designing the NQTL**

The following factors are used to establish the Aetna Market Fee Schedule ("AMFS"), which is the preferred fee schedule for MH/SUD and M/S network providers.

When a provider does not accept the AMFS, the AMFS is used as a starting point for contract negotiations.

**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 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, the rate from Optum (a third party) is used; where there is no Optum rate, the Developed Aetna Rate Table ("DART") rate is used, which is 80% of the average allowed amount.

**Market dynamics:** The local networks establish their own AMFS rates to take into consideration the unique characteristics of that market including supply and demand, the carrier’s market penetration compared to other carriers and networks, other payors’ rates (competitors, Medicaid), and any other relevant characteristics specific to that market.

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

**Unit Cost Trend Target:** This refers to the percentage of unit cost by which the network determines it can adjust overall M/S and MH/SUD rates when refreshing them. Plans establish unit cost trend targets for provider contract rates so they can estimate future health care costs in order to set appropriate targets.
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 than AMFS, 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:

1. Develop the AMFS rates.
   a. Aetna's Medical Economics Unit (MEU) identifies the CMS RBRVS rates for the service codes and proposes the AMFS rates as a percentage of the CMS rates. (Variations: Where there is no CMS rate for a code, the Optum rate is used; where there is no Optum rate, the DART rate is used. Also, a network may choose to use a flat rate instead of a percentage of CMS rates for some services. MEU communicates the preliminary rates to network management.
   b. Aetna's BH and local market network management in collaboration with MEU adjusts those preliminary rates up or down (or makes no adjustment) based on the network's analysis of market dynamics. This results in the final AMFS rates.
   c. For service types that are billed both by MH/SUD and M/S providers, after the rate for M/S providers is determined the rate for the same service for MH/SUD providers is set at or above that rate.
   d. For both MH/SUD and M/S providers, rates are tiered based on provider type/level of training:
      - MD’s (MH/SUD and M/S) & Clinical Psychologists receive 100% of the rate.
      - Nurse Practitioners, Physician Assistants and Certified Nurse Specialist (MH/SUD and M/S) receives 85% of the new rate.
      - Drug and Alcohol Counselor, Licensed Professional Counselor, Marriage and Family Therapist, Pastoral Counselor, Social Worker receive 75% of the new rate.
      - Audiologist, Registered Dietician, Genetic Counselor, Massage Therapist, Nutritionist, Respiratory Therapist receive 75% of the new rate.
      This is consistent with CMS methodology—see Medicare Claims Processing Manual Chapter 12, available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf. For example, see section 110, which indicates Medicare pays physician assistants 80% of the lesser of the actual charge or 85% of what a physician would be paid for the same service, and section 150, which indicates Medicare pays 75% of the physician fee schedule for clinical social worker services.)

   a. 2. Update the AMFS rates periodically. The frequency varies by market. The AMFS for the Illinois market was most recently updated in 2022. The next update is scheduled for 2024.
      - To refresh the AMFS rates for M/S services, and MH/SUD services that are not also billable by M/S providers, MEU indexes the rates against CMS rates and adjusts the rates for various service code ranges to maintain cost neutrality. BH and local market network management collaborate with MEU to make adjustments based on their understanding of market dynamics.
      - To refresh the AMFS rates for MH/SUD providers for the service codes that can also be billed by M/S providers, those rates are compared to the M/S AMFS rates to develop the AMFS rates for MH/SUD providers. That process works as follows:
         The Medical and BH network and MEU personnel agree on when the AMFS rates will be refreshed for a given market. After the Medical network finalizes the refreshed rates for the codes shared with MH/SUD providers, those rates are communicated to BH network personnel. BH network personnel, supported by MEU, compare the refreshed rates to the existing rates for MH/SUD providers. If the refreshed M/S rate is higher, the BH network will adopt the M/S rate or a rate that is higher (but not lower) than the M/S rate. The refreshed MH/SUD rates are effective at the same time as the refreshed M/S rates. MH/SUD rates can also be refreshed apart from Medical's rate refresh, which occurs when the American Medical Association releases new CPT4® codes for MH/SUD services or when the BH network team observes that the volume of nonstandard rates in provider contracts has increased due to provider demand for higher reimbursement.

   For more detail about steps 1 and 2, refer to the Aetna Market Fee Schedule Rate Development Policy & Procedure for Non-Facility Providers.
3. Use the AMFS rates as the basis for contracting with providers.
   
a. When seeking to contract with a new provider, the contract negotiator proposes the AMFS rates as the Negotiated Charges. If the provider agrees, then the AMFS rates become the Negotiated Charges. If the provider does not agree to AMFS, the contract negotiator offers adjustments to the rates in light of the Unit Cost Trend Target, until the parties agree on the final Negotiated Charges. Provider Leverage is the key factor in determining whether and by how much the final Negotiated Charges differ from the proposed rates. (Variation: Whereas AMFS is the preferred basis for contract with providers, it is possible that a different percentage of AMFS or an alternate methodology may be agreed upon, either for some or all service codes. The parties may agree to lower rates for some services but higher rates for others.

b. When the AMFS is refreshed, the refreshed rates are communicated to network providers at least 90 days before they take effect, and according to whether the provider's contract permits rate changes. Providers may seek to negotiate the changes, and the unit cost trend target and provider leverage determine whether the parties will agree to the refreshed AMFS rates as the new Negotiated Charges or negotiate something different.

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<tr>
<th>Service Code</th>
<th>M/S Physician</th>
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<th>Medicare 4Q22</th>
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</table>

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

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.

AMFS (Office-Based Providers):
(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; it is because the MH/SUD network is managed by a national team whereas the M/S networks are managed at the market level. As for Provider Leverage, it is specific to the circumstances of the particular contract negotiation; a MH/SUD provider may have more leverage in a given negotiation than a M/S provider, and vice versa.

Even though the Plan’s factors, processes and evidentiary standards for developing and maintaining the AMFS for MH/SUD rates are not more stringent than for M/S rates, the final Negotiated Charges resulting from contract negotiations may not reflect identical or more favorable MH/SUD rates in every instance. Provider groups and individual providers are free to negotiate rates different from the fee schedules, and the bargaining power they bring to such negotiations may result in Negotiated Charges that are different from the AMFS rates.

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:

• Aetna Market Fee Schedule
• Rate Development Policy and Procedure for Non-Facility Providers
• IL BH_Med AMFS
### 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:**
Applies to all M/S benefits delivered in-network

**MH/SUD services NQTL applies to:**
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. Also includes consultants' analyses of Aetna’s discount position in the market compared to other carriers, and what Aetna pays other facilities.

- **Market dynamics:** The local networks establish their own reimbursement strategies to take into consideration the unique characteristics of that market including supply and demand, the carrier’s market penetration compared to other carriers and networks, other payors’ rates (competitors, Medicaid), and any other relevant characteristics specific to that market.

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

**Unit Cost Trend Target:**

This refers to the percentage of unit cost by which the network determines it can adjust overall M/S and MH/SUD rates when refreshing them.

Plans establish unit cost trend targets for provider contract rates so they can estimate future health care costs in order to set appropriate premiums. The trend target is a baseline in which to begin the negotiations with providers. The network teams still negotiate with providers as needed to maintain an adequate network even if that means their overall trend target is exceeded.

To establish the trend target, Aetna’s Medical Economics Unit (MEU) performs analyses of utilization, current network rates, estimated competitor unit cost trends, and the provider contracts up for renewal that year to create unit cost increase targets for the network teams to aim for when contracting with network providers. MEU uses an Aetna tool called pModel to do these analyses. Unit cost trend targets are set at an overall market level, not at the level of individual providers (except that the trend target for the...
Provider leverage: AKA bargaining power.

**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:** BH and local market network management and the Medical Economics Unit (MEU) examine what Aetna pays other facilities in the area and what competitive data reveals regarding what competitors are paying (though BH network does not currently use competitive data). The provider type, scope and complexity of the services, and service types are considered, along with market dynamics. Based on this, a proposed reimbursement methodology and set of rates are offered to the facility. For M/S facilities there is no standard or preferred proposed reimbursement methodology (e.g., per diem, fee for service, DRG, % of charges) or set of rates when contracting with a new facility. For MH/SUD facilities the standard proposed reimbursement methodology is per diem. Rates for MH/SUD service codes that can also be billed by M/S facility-based professionals are set at or above the rate established for M/S providers.

After the contract negotiator proposes contract terms and reimbursement rates, the provider may accept them or seek to negotiate. The contract negotiator may offer adjustments to the rates in light of the Unit Cost Trend Target, until the parties agree on the final Negotiated Charges. Provider Leverage is the key factor in determining whether and by how much the final Negotiated Charges differ from the proposed rates.

**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.

A comparison of Negotiated Charge amounts between facilities that are paid using different reimbursement methodology(s) such as DRG versus per diem, and for different services, is not possible because they are too disparate to allow comparison. Nevertheless, there are some professional services that can be billed by both MH/SUD and M/S facility-based providers, and under some facility contracts those may be reimbursed on a fee for service basis using AMFS. For those shared codes, the AMFS rates are higher for MH/SUD providers than M/S providers. This is demonstrated by reviewing AMFS rates for shared codes in a sample market in this case Suburban Chicago, IL. For example, the rates for facility-based MH/SUD physicians are higher than for facility-based M/S physicians for the four most frequently billed shared codes, as shown by this chart:

<table>
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<td>$103.22</td>
</tr>
</tbody>
</table>

Even though Aetna’s factors, processes and evidentiary standards for developing and maintaining the AMFS for MH/SUD rates are comparable and not more stringent than for M/S rates, the final Negotiated Charges will not reflect identical or more favorable MH/SUD rates in every instance. Providers are free to negotiate rates different from the proposed fee schedule, and their bargaining power may result in Negotiated Charges that are different from the AMFS rates.

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:**